

5947

05937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1mth12dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Packard</b> Last <b>Adams</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1896</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress (rtd)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Packard</b>				14. MOTHER'S MAIDEN NAME <b>Mary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-01-4647</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured heart</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic infarction</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease with hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 24</b> , 19 <b>57</b> , to <b>June 11</b> , 19 <b>57</b> that I last saw the deceased alive on <b>June 11</b> , 19 <b>57</b> , and that death occurred at <b>1:00a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>		ADDRESS (Street, city or town, state) <b>Catonsville 28, Maryland</b>		DATE SIGNED <b>6-11-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons - Balt.</b>				24a. REC'D BY REGISTRAR <b>DATE 6/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. [Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		PATHOLOGICAL FINDINGS	
LABORATORY TESTS		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF WITNESSES		SIGNATURE OF DEATH REGISTRAR	

RECEIVED  
JUN 13 1957  
BUREAU V. S.

5948

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN TB <b>39 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>810 Homestead Street</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>W.</b> Last <b>AMSPACHER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/1/15</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Veterans Admin.</b>		11. BIRTHPLACE (State or foreign country) <b>Glen Rock, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Edward W. Amspacher, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Nelson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>577-22-3621</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>3 WEEKS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 6, 1957</b> , to <b>June 14, 1957</b> , and that death occurred at <b>4:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/14/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd., Balto 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lacey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# CERTIFICATE OF DEATH

Form No. 10

DEPARTMENT OF HEALTH - BALTIMORE DIVISION OF VITAL RECORDS		DATE OF DEATH JAN 19 1957	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

RECEIVED

JUN 19 1957

BUREAU V. S.



5949

## CERTIFICATE OF DEATH

05939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneligh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 year Townson Ballto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cal Home</u>				d. STREET ADDRESS <u>1610 Taperpoint Rd-</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Atwell</u>				4. DATE OF DEATH Month Day Year <u>June 24 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George G. Atwell</u>		14. MOTHER'S MAIDEN NAME <u>Wm. Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. W. E. Putnam 1610 Taperpoint Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> DUE TO (c) <u>arteriosclerosis, severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 15, 1957</u> , to <u>June 24, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>3:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Gilmore</u> M.D.				DATE SIGNED <u>6/24/57</u>			
PHYSICIAN'S NAME (Type) <u>G. T. GILMORE, MD</u>				LUTHERVILLE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremated</u>		<u>June 26/57</u>		<u>Baltimore</u>		<u>Baltimore md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>Edward M. ...</u>				<u>JUN 26 1957</u>		<u>Mark ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. DATE [Faint text]</p>	

BUREAU V. S.

JUN 26 1957

RECEIVED

5950

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>1 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson Hospital</b>				d. STREET ADDRESS <b>16X1-2</b>			
3. NAME OF DECEASED (Type or print) First <b>ROLAND</b> Middle <b>MURPHY</b> Last <b>BADEN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-4-01</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THOMAS W. BADEN</b>				14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXX</del> <b>Lillie Hyde</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MENINGITIS</b> <b>010X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS, AGRANULOCYTOSIS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-4-1956</b> to <b>6-1-1957</b> that I last saw the deceased alive on <b>6-1-1957</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>6/1/57</b>							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>WILLIAM NEWCOMER, M. D., SUPERINTENDENT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baden Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 6 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Lorothy Newell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

ACUTE MENINGITIS

PULMONARY TUBERCULOSIS (AGRAUOLOCITIC)

BUREAU V. S.

JUN 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5951  
CERTIFICATE OF DEATH

05941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE (6)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 ROSEDALE (6)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1303 PHILA. RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LILLIAN GETTMAN BAERWALD</b>				4. DATE OF DEATH <b>6-3-1957</b>			
5. SEX <b>FEM.</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 6, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN GETTMAN</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE SCAGGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Rudolph Baerwald</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Art. Septic Heart Disease</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hr ± 20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1957</b> , to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. W. Winkor</b>				ADDRESS (Street, city or town, State) <b>520 D St, Balt, Md</b>			
PHYSICIAN'S NAME (Type) <b>Roger Winkor, M.D.</b>				DATE SIGNED <b>June 4, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>6-6-57</b>		<b>OAK LAWN</b>		<b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter B. Bradley, Dundalk, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith A. Huley</b>	



RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05942

5952

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>9 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>IRENE</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1872</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WALTER C. FOSTER</b>				14. MOTHER'S MAIDEN NAME <b>EMMA J. COLLINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Hypostatic pneumonia</b> DUE TO (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>other 345</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170X Cancer of breast with metastases - other 345</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6-14</b> , 19 <b>57</b> , to <b>6-22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-22</b> , 19 <b>57</b> , and that death occurred at <b>3:58 P</b> M, from the causes and at the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Cook</b>				ADDRESS (Street, city or town, state) <b>Cockeysville Md</b>			
PHYSICIAN'S NAME (Type) <b>Walter T. Cook</b>				DATE SIGNED <b>6/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baker's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 25 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. T. Cook</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH JUN 23 1968	
PLACE OF DEATH MEMPHIS, TENNESSEE		CITY OF DEATH MEMPHIS	
AGE 35		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION CONTRACTOR		MARRIAGE MARRIED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ATHEROSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNS AND SYMPTOMS PAIN IN CHEST, SHORTNESS OF BREATH		TREATMENT MEDICATION	
HISTORY NO SIGNIFICANT HISTORY		FAMILY HISTORY NO SIGNIFICANT HISTORY	
SOCIAL HISTORY NO SIGNIFICANT HISTORY		HABITS NO SIGNIFICANT HISTORY	
MEDICAL HISTORY NO SIGNIFICANT HISTORY		SURGICAL HISTORY NO SIGNIFICANT HISTORY	
PATHOLOGICAL FINDINGS CORONARY ARTERY DISEASE		LABORATORY FINDINGS NORMAL	
POST-MORTEM FINDINGS CORONARY ARTERY DISEASE		TOXICOLOGICAL FINDINGS NO SIGNIFICANT HISTORY	
FORENSIC FINDINGS NO SIGNIFICANT HISTORY		OTHER FINDINGS NO SIGNIFICANT HISTORY	

RECEIVED  
JUN 25 1967  
BUREAU V. 2

5953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>56 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>611 Montpelier Street</b>			
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>LeRoy</b> Middle <b>(NMI)</b> Last <b>BANKS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1891</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Robert Banks</b>				14. MOTHER'S MAIDEN NAME <b>Mary G. Drummond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>215-10-0184</b>		17. INFORMANT <b>Clin. Rec., Vet Adm. Hosp., Ft. Howard, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>832x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>CEREBRAL THROMBOSIS</b> DUE TO (c) <b>CEREBRAL ATHEROSCLEROSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>334x</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>April 16, 1957</b> to <b>June 11, 1957</b> and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur G. Edwards</b>				ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b>		DATE SIGNED <b>6/11/57</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR G. EDWARDS, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Funeral Home, 5305 Harford Rd. Baltimore, Md.</b>				24. REC'D BY REGISTRAR <b>JUN 13 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Lawson L. Luby</b>			

JUN 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5954

## CERTIFICATE OF DEATH

Reg. Dist. No. 05944

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>				d. STREET ADDRESS <b>5922 Charnwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ETHYL</b> Last <b>BARKMAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 28, 1888</b> 68 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Barkman</b>				14. MOTHER'S MAIDEN NAME <b>Lottie R. Wedi</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Robt. Mugford - 106 W. University Pkwy</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Arterio Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 yr</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>290.0 Pernicious Anemia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1956</b> , to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>1306</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>James W. Katzenberger</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. James W. Katzenberger</b>				4123 Frederick Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				24a. REC'D BY REGISTRAR <b>June 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

JUN 25 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5955

Item 2 Film G217 6-24-57 et

## CERTIFICATE OF DEATH

05945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEWOOD NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>VINYARD</b> Last <b>BARNES</b>				4. DATE OF DEATH <b>6/12/57</b> Day Year 19			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1890</b>	
9. AGE (In years birth day) yrs. <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Charles E. Vinyard</b>				14. MOTHER'S MAIDEN NAME <b>Emma Wagner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>---</b>			
17. INFORMANT <b>Mr. Samuel E. Barnes</b>				Address <b>1172 St. Agnes Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of</b> <b>1999</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>primary source unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left pleural effusion, cellulitis; Rheum. C.V.D.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>12/14</b> , 19 <b>56</b> to <b>6/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/12</b> , 19 <b>57</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>5721 Park Boulevard Baltimore 15, Md</b>			
DATE SIGNED <b>6/13/57</b>							
PHYSICIAN'S NAME (Type) <b>DANIEL WILFSON M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. City</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick A. Cole</b>				ADDRESS <b>1913 W. Balto. St.</b>		24a. REC'D BY REGISTRAR <b>JUN 17 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Outreach</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

JUN 17 1957

RECEIVED

## 5956 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>Emma Beaumont</b>			2. DATE OF DEATH <b>June 21, 1957</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Catonsville</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Shady Nook Nursing Home</b> <b>1002 Rolling Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>223 Blakeney Rd.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 8, 1868</b>		9. AGE (In years, last birthday) <b>89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>?</b> <b>Naff</b>			14. MOTHER'S MAIDEN NAME <b>Mary E.</b> <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>P.O. Box 127</b> <b>Mr. Lawrence L. Roden, Arnold, A.A. Co. Md.</b>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>450.0</b> <b>ANTCEDENT CAUSES</b>			CAUSE OF DEATH (A) <b>BROUCHO PNEUMONIA</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>491X</b>			(B) <b>ARTERIO SCLEROSIS GEN.</b> DUE TO		<b>10 YRS.?</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) ...		
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6/18</b> , 1957 to <b>6/21</b> , 1957, that I last saw the deceased alive on <b>6/21</b> , 1957, and that death occurred at <b>5:00</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Paul R. ZIEGLER</b> M.D.		23B. ADDRESS <b>3723 EDMUNDSON AVE</b>		23C. DATE SIGNED <b>6/22/57</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/24/1957</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>6-24-57</b>		REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>		25. FUNERAL DIRECTOR <b>Wm. J. Tiedman &amp; Sons - Balto, Md.</b>	

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1957

BUREAU V. S.

## 5957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>in transit</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> <b>XO</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>in Reist. Ambulance on way to Balto.</b>				d. STREET ADDRESS <b>Old Hanover Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>A.</b> Last <b>Bell</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>March 5, 1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man at Inn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Bell</b>				14. MOTHER'S MAIDEN NAME <b>Sally</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-7189</b>		17. INFORMANT <b>Mrs. Thomas Wolfe, Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>581.0 Portal Cirrhosis of Liver- 2 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>A. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/28/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary B Eline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		DATE OF DEATH July 5, 1957	
RESIDENCE 123 Main St, Baltimore, Md.		OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home	
FAMILY HISTORY None		PREVIOUS ILLNESS None		SIGNS AND SYMPTOMS None		TESTS AND EXAMINATIONS None		TREATMENT None	
SIGNATURE OF MEDICAL EXAMINER [Signature]		DATE July 5, 1957		TIME 10:00 AM		LOCATION Baltimore, Md.		OFFICE [Signature]	

BUREAU V. S.

JUL 5 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5958

## CERTIFICATE OF DEATH

Reg. Dist. No.

05948

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>132 Back River Neck Rd.</u>				d. STREET ADDRESS <u>132 Back River Neck Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Anthony</u> Middle <u>Bengies</u> Last				4. DATE OF DEATH <u>June 12 1957</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 18 - 1903</u> 33 yrs.	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship-Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth-Ship</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW BENGIES</u>				14. MOTHER'S MAIDEN NAME <u>NADOLNY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CATHERINE BENGIES</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1 yr.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>57</u> , to <u>6/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>57</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.M. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto Md</u>			
PHYSICIAN'S NAME (Type) <u>J.M. Baumgardner</u>				DATE SIGNED <u>6/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK-LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly - Essex</u>				24a. RECEIVED BY REGISTRAR <u>John G. Connelly</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Harley</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *JOHN J. BROWN*

2. SEX: *MALE*

3. AGE: *45*

4. DATE OF BIRTH: *1912*

5. PLACE OF BIRTH: *NEW YORK*

6. OCCUPATION: *LABORER*

7. CAUSE OF DEATH: *HEART DISEASE*

8. DATE OF DEATH: *JUN 15 1957*

9. PLACE OF DEATH: *HOSPITAL*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. S.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5959

## CERTIFICATE OF DEATH

Reg. Dist. No.

05949

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 159 Bird River Grove Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Richard P. Bentz</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore Transit Co Electrical</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Bentz</u>				14. MOTHER'S MAIDEN NAME <u>Marcella Fahey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-10-0337</u>		17. INFORMANT <u>Mrs. Katherine Bentz, Box 159 Bird River Grove Road.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiogenic carcinoma</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>57</u> to <u>6/24</u> , 19 <u>57</u> that I last saw the deceased alive on <u>6/21</u> , 19 <u>57</u> , and that death occurred at <u>8: a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George D. Edwards</u>				ADDRESS (Street, city or town, state) <u>9660 Belair Road, Baltimore, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>George D. Edwards.</u>				DATE SIGNED <u>6/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>JUN 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Smith</u>			

☒ 2008-09-01

BUREAU V. S.

JUN 26 1957

RECEIVED

5960

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1400 Park Ave 3v101-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clark Hill Home</u>		d. STREET ADDRESS <u>Baltimore-17</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>White</u> Last <u>Bingley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9 1887</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Secretary</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Rev. Chas. V. Bingley</u>		14. MOTHER'S MAIDEN NAME <u>Ella McCLean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-1549</u>	
17. INFORMANT <u>Wm. Bingley</u>		Address <u>504 Minnie @</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>148 hours</u> <u>5 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December, 1948</u> , to <u>15 June, 1957</u> , that I last saw the deceased alive on <u>15 June, 1957</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>J. Douglas Lockard</u>		M.D. <u>202 Cathedral St</u>	
PHYSICIAN'S NAME (Type) <u>J. Douglas Lockard Baltimore-1, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 18 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore-29-Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Morris</u>		ADDRESS <u>108 W. North Baltimore</u>	24a. REC'D BY REGISTRAR <u>JUN 18 57</u>
		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 4

JUN 18 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05951

5961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>15yr7mth4days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3 Vol. 4</b>		
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle Last <b>Blechman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1863</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Isaac Blechman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>				INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 29</b> , 19 <b>57</b> , to <b>June 4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 4</b> , 19 <b>57</b> , and that death occurred at <b>1:56p.M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-4-57</b>		
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-6-57</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Mem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		24a. REC'D BY REGISTRAR <b>2100 Burton Place</b>		
24b. REGISTRAR'S SIGNATURE <b>Qu. Leach</b>		DATE <b>JUN 6 57</b>		

**BUREAU V. S.**

RECEIVED

NOT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# 5962 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u>		c. LENGTH OF STAY IN 1b <u>hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7644 DULANEY A</u>	
3. NAME OF DECEASED (Type or print) <u>DOUGLAS A. BOBLITZ</u>		4. DATE OF DEATH <u>6</u> Month <u>18</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14-1911</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eng. Firm</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>DOUGLAS A. BOBLITZ Sr</u>	
14. MOTHER'S MAIDEN NAME <u>MARIE LITTLE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>413-07-4393</u>		17. INFORMANT <u>HATTIE M. BOBLITZ</u> Address <u>7644 DULANEY A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury of Skull</u> 9153 DUE TO <u>Partial Decapitation.</u> Conditions, if any, which gave rise to immediate cause (b) <u>1st Body 2nd Burns &amp; 50% Body</u> DUE TO <u>3rd Burns-Amputation Rt lower leg</u> (c) <u>Explosion of</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>WELDING A PRESSURE TANK FULL OF OXYGEN-180lb PRESSURE PER sq inch</u>			20b. DECEASED HOW INJURED OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>130</u> a.m. <u>6</u> p.m. <u>18</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>	20f. (City or town) <u>GLEN ARM</u> (County) <u>BALTO</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-21-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) <u>BALTO MD</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. M. Walters</u>		ADDRESS <u>PRATT ST</u>	
24a. REC'D BY REGISTRAR <u>SPICER</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walters</u>	
DATE <u>20 1957</u>			

BUREAU V. 8

JUN 20 1957

RECEIVED

5963

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			c. LENGTH OF STAY IN 1b <b>34 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 Berrymans Lane</b>				d. STREET ADDRESS <b>Berrymans Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Flynn Bollinger</b>				4. DATE OF DEATH <b>June 10, 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1923</b>	
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
13. FATHER'S NAME <b>Patrick Flynn</b>				14. MOTHER'S MAIDEN NAME <b>Margaret</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>J. Edward Bollinger, Towson 4, Md.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November</b> , 19 <b>55</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 4</b> , 19 <b>57</b> , and that death occurred at <b>8:15 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b> M.D.				ADDRESS (Street, city or town, state) <b>Reisterstown, Maryland</b>		DATE SIGNED <b>June 11, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13/47</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6-12-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B Eline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased <b>William Polington</b>		Sex <b>Male</b>		Age <b>74 yrs</b>	
Date of Death <b>June 10, 1967</b>		Place of Death <b>At Home</b>		Cause of Death <b>Heart Disease</b>	
Residence <b>101 East Main Street, Boston, Mass.</b>		Usual Residence <b>Same as above</b>		Place of Birth <b>Boston, Mass.</b>	
Manner of Death <b>Natural</b>		Occupation <b>Retired</b>		Education <b>High School</b>	
Marital Status <b>Married</b>		Spouse's Name <b>Elizabeth Polington</b>		Spouse's Date of Birth <b>1893</b>	
Date of Marriage <b>1915</b>		Place of Marriage <b>Boston, Mass.</b>		Number of Children <b>4</b>	
Signature of Physician <b>[Signature]</b>		Signature of Registrar <b>[Signature]</b>		Signature of Deceased <b>[Signature]</b>	
Date of Signature <b>June 13, 1967</b>		Date of Signature <b>June 13, 1967</b>		Date of Signature <b>June 13, 1967</b>	

BUREAU V. 3

JUN 13 1967

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

5964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05954

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>	c. LENGTH OF STAY IN 1b <u>20 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster Rd.</u>		d. STREET ADDRESS <u>Glen Falls Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Russel Bosley Jr.</u>		4. DATE OF DEATH Month Day Year <u>June 7 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1944</u>
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months Days <u>12</u> <u>12</u>	IF UNDER 24 HRS. Hours Min. <u>20</u> <u>min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (State or foreign country) <u>California</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Russel Bosley, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Myrtle Lovo</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles Russel Bosley Sr., Glen Falls Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning- accidental</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>929.8</u> (c) <u>929.8</u> DUE TO stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went swimming and didn't come up.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>June 7, 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Liberty Reservoir</u>		20f. (City or town) (County) (State) <u>Reisterstown, Balto., Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville</u>		24a. REC'D BY REGISTRAR <u>June 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 8

JUN 11 1957

RECEIVED

5965

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yr2mth4dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Grace</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>about 1870</u> <u>unknown</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John McGlocklin</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Heath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>family brain disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 11, 1956</u> , to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John Vasconcellos</u> M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) <u>JOHN VASCONCELLOS</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. [illegible]</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 25 57</u>		24b. REGISTRAR'S SIGNATURE <u>[illegible]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5966

## CERTIFICATE OF DEATH

05956

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville-28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> X0			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>				d. STREET ADDRESS <u>1810 Colonial Road-Balto. 7, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>BOWEN</u>			4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>19 57</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1897</u>	9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frederick Simms</u>				14. MOTHER'S MAIDEN NAME <u>Marcella Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Clarence R. Bowen-Box 25-Prince Frederick, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Melanoma</u> <u>190x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>57</u> , to <u>6/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>57</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton Schenoff</u> M.D. <u>6410 Windsor Mills Rd</u>			DATE SIGNED <u>6/27/57</u>				
PHYSICIAN'S NAME (Type) <u>Milton Schenoff</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Tuckner &amp; Sons</u> ADDRESS <u>North &amp; Pa Aves</u>				24a. REC'D BY REGISTRAR <u>JUL 1 '57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU V. S.

2 1957

RECEIVED



5967

## CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2 Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5408 W. North Ave.,</b>		d. STREET ADDRESS <b>5408 W. North Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Carrie Lillian Boyd</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>William Wenner</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Orisson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-01-3645</b>	
17. INFORMANT <b>William N. Boyd</b>		Address <b>5408 W. North Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA TO THE LIVER; LIVER FAILURE</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF THE RECTOSIGMOID COLON</b> DUE TO (c) <b>9 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , to <b>June 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>JUNE 18</b> , 19 <b>57</b> , and that death occurred at <b>6:00A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5101 Gwynn Oak Ave. Baltimore, 7, Maryland</b> 19 <b>June 1957</b>			
ACTUAL SIGNATURE <b>Millard T. Traband</b>		M.D. <b>5101 Gwynn Oak Ave. Baltimore, 7, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr. M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-22-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3207 W. ALBANY AVE.</b>	
24a. REC'D BY REGISTRAR <b>JUN 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. M. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05958

5968

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Briggs</b> Last <b>Briggs</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1910</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sander</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>furniture fact.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ferdinand Briggs</b>				14. MOTHER'S MAIDEN NAME <b>Emily Kurtz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>071-07-4344</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 16</b> , 19 <b>57</b> , to <b>June 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 13</b> , 19 <b>57</b> , and that death occurred at <b>1:00aM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
DATE SIGNED <b>6-13-57</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maryland Line Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Maryland Line, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Fortinaker, New Freedom, Pa.</b>				24a. REC'D BY REGISTRAR <b>JUN 17 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JUN 17 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Rosewood School</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>1340 North Washington Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Brooks</u> Last <u>Brooks</u>		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-29</u>
9. AGE (In years last birthday) yrs. <u>27</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>deceased</u>		14. MOTHER'S MAIDEN NAME <u>deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Brother Mr. Charles Brooks</u>		Address <u>1107 Skelwood Ave BAIT, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal hypertension</u> DUE TO (c) <u>Nephrosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>353.3 Congenital epilepsy</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/3/36</u> , 19 <u>36</u> , to <u>6/13/57</u> , 19 <u>57</u> . That I last saw the deceased alive on <u>6/13/57</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. <u>Rich. S. Rosenberg (Physic.)</u> <u>6/14/57</u> ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Rich. Rosenberg</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>June 17, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Rosewood</u>		<u>Owings Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>J.F. Eline &amp; Sons</u>		<u>Reisterstown, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>6-17-57</u>		<u>Harry B. Shinn</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUN 18 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6217 6-26-57 et

5970

## CERTIFICATE OF DEATH

Reg. Dist. No.

05960

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>60 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>Formerly of 760 Poplar Grove St</b>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>D. Brunshear</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1876</b>
9. AGE (In years birth day) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Brunshear</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Helen A. Shirey</b>		Address <b>1919 Frederick Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephritis, chronic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>443X Hypertensive Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 10, 1955</b> to <b>JUNE 18, 1957</b> , that I last saw the deceased alive on <b>JUNE 18, 1957</b> , and that death occurred at <b>1259 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b>		DATE SIGNED <b>June 19, 1957</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER</b>		ADDRESS (Street, city or town, state) <b>401 RANDOM RD. BALTO. 29 MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>		24a. REC'D BY REGISTRAR <b>400E</b>	
ADDRESS <b>4101 Edmondson Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		OCCASION OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]	

BUREAU V. &

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5971

## CERTIFICATE OF DEATH

05961

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3413 Kimble Road</u>				d. STREET ADDRESS <u>3413 Kimble Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>F.</u> Last <u>Bull</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 4, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Leonard F. Bull</u>				14. MOTHER'S MAIDEN NAME <u>Ella C. Wooden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-4857</u>		17. INFORMANT Address <u>Mrs. Alice M. Bull 3413 Kimble Road, Rockdale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Failure &amp; coronary</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>462.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. j. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>53</u> , to <u>6/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>57</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.				ADDRESS (Street, city or town, state) <u>2204 LIBERTY Rd BALTO. Md</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u>				DATE SIGNED <u>6/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> ADDRESS <u>3631 Falls Road Balto.</u> <u>Norace F. Burgee</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Masten</u>			

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RECEIVED

5972

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4			
f. STREET ADDRESS <b>409 E. Fort Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>R.</b> Last <b>BUSICK</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1886</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George L. Busick</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elliott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION WITH HEMOPERICARDIUM</b> <b>420.1</b> DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>UNKNOWN</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> attended the deceased from <b>June 15</b> , 19 <b>57</b> , to <b>June 19</b> , 19 <b>57</b> . <del>He died on</del> and that death occurred at <b>8:50 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Armen Bogosian</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>6/20/57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James L. McCully Funeral Home, 237 Patapsco, Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 24 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Fisher</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JUNE 24, 1957	
AGE		SEX	
78		Male	
RACE		OCCUPATION	
White		Retired	
MARRIAGE		PLACE OF BIRTH	
Married		Maryland	
EDUCATION		CAUSE OF DEATH	
High School		Heart Disease	
RELIGION		MANNER OF DEATH	
Roman Catholic		Natural	
FAMILY HISTORY		HISTORICAL DATA	
None		None	
PREVIOUS ILLNESS		DATE OF BURIAL	
None		June 25, 1957	
PLACE OF DEATH		PLACE OF BURIAL	
Home		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE	
June 24, 1957		June 24, 1957	

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JUN 24 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05963

5973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Rosedale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7902 Philadelphia Road</b>		d. STREET ADDRESS <b>7902 Philadelphia Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>J.</b> Last <b>Butala Sr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Farrell, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Stephen Butala</b>		14. MOTHER'S MAIDEN NAME <b>Anna Halvskä</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>149-16-4880</b>	
17. INFORMANT <b>May W. Butala</b>		Address <b>7902 Philadelphia Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastases</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/15</b> , 19 <b>57</b> , to <b>6/9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/9</b> , 19 <b>57</b> , and that death occurred at <b>6:45</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul J. Black</b> M.D.		ADDRESS (Street, city or town, state) <b>914 N. Charles St.</b> DATE SIGNED <b>6/11/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 12, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>		24a. REC'D BY REGISTRAR <b>JUN 12 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Edith Kurling</b>			

JUN 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05964

5974

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR-8 MO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> 01222 ✓	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>G.</b> Last <b>CALDWELL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>19 57.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES C. GORSUCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE CONKLING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiac</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>10-28</b> , 19 <b>55</b> , to <b>10-19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-19</b> , 19 <b>57</b> , and that death occurred at <b>4:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter T. Lees</b>		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	
M.D. <b>6/21/57</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook Inc.</b>		24a. REC'D BY REGISTRAR <b>24 57</b>	
ADDRESS <b>1217 St. Paul Street Balto</b>		24b. REGISTRAR'S SIGNATURE <b>Perkins</b>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH</p>		<p>6. OCCUPATION                  7. MARITAL STATUS                  8. COLOR                  9. RELIGION</p>	
<p>10. CAUSE OF DEATH                  11. PLACE OF DEATH                  12. DATE OF DEATH</p>		<p>13. SIGNATURE OF PHYSICIAN                  14. SIGNATURE OF REGISTRAR</p>	
<p>15. NAME OF FUNERAL HOME                  16. ADDRESS OF FUNERAL HOME</p>		<p>17. NAME OF NEXT OF KIN                  18. ADDRESS OF NEXT OF KIN</p>	
<p>19. NAME OF BURIAL PLACE                  20. ADDRESS OF BURIAL PLACE</p>		<p>21. NAME OF CEMETERY                  22. ADDRESS OF CEMETERY</p>	
<p>23. NAME OF CORPSE                  24. ADDRESS OF CORPSE</p>		<p>25. NAME OF CORPSE                  26. ADDRESS OF CORPSE</p>	
<p>27. NAME OF CORPSE                  28. ADDRESS OF CORPSE</p>		<p>29. NAME OF CORPSE                  30. ADDRESS OF CORPSE</p>	
<p>31. NAME OF CORPSE                  32. ADDRESS OF CORPSE</p>		<p>33. NAME OF CORPSE                  34. ADDRESS OF CORPSE</p>	
<p>35. NAME OF CORPSE                  36. ADDRESS OF CORPSE</p>		<p>37. NAME OF CORPSE                  38. ADDRESS OF CORPSE</p>	
<p>39. NAME OF CORPSE                  40. ADDRESS OF CORPSE</p>		<p>41. NAME OF CORPSE                  42. ADDRESS OF CORPSE</p>	
<p>43. NAME OF CORPSE                  44. ADDRESS OF CORPSE</p>		<p>45. NAME OF CORPSE                  46. ADDRESS OF CORPSE</p>	
<p>47. NAME OF CORPSE                  48. ADDRESS OF CORPSE</p>		<p>49. NAME OF CORPSE                  50. ADDRESS OF CORPSE</p>	
<p>51. NAME OF CORPSE                  52. ADDRESS OF CORPSE</p>		<p>53. NAME OF CORPSE                  54. ADDRESS OF CORPSE</p>	
<p>55. NAME OF CORPSE                  56. ADDRESS OF CORPSE</p>		<p>57. NAME OF CORPSE                  58. ADDRESS OF CORPSE</p>	
<p>59. NAME OF CORPSE                  60. ADDRESS OF CORPSE</p>		<p>61. NAME OF CORPSE                  62. ADDRESS OF CORPSE</p>	
<p>63. NAME OF CORPSE                  64. ADDRESS OF CORPSE</p>		<p>65. NAME OF CORPSE                  66. ADDRESS OF CORPSE</p>	
<p>67. NAME OF CORPSE                  68. ADDRESS OF CORPSE</p>		<p>69. NAME OF CORPSE                  70. ADDRESS OF CORPSE</p>	
<p>71. NAME OF CORPSE                  72. ADDRESS OF CORPSE</p>		<p>73. NAME OF CORPSE                  74. ADDRESS OF CORPSE</p>	
<p>75. NAME OF CORPSE                  76. ADDRESS OF CORPSE</p>		<p>77. NAME OF CORPSE                  78. ADDRESS OF CORPSE</p>	
<p>79. NAME OF CORPSE                  80. ADDRESS OF CORPSE</p>		<p>81. NAME OF CORPSE                  82. ADDRESS OF CORPSE</p>	
<p>83. NAME OF CORPSE                  84. ADDRESS OF CORPSE</p>		<p>85. NAME OF CORPSE                  86. ADDRESS OF CORPSE</p>	
<p>87. NAME OF CORPSE                  88. ADDRESS OF CORPSE</p>		<p>89. NAME OF CORPSE                  90. ADDRESS OF CORPSE</p>	
<p>91. NAME OF CORPSE                  92. ADDRESS OF CORPSE</p>		<p>93. NAME OF CORPSE                  94. ADDRESS OF CORPSE</p>	
<p>95. NAME OF CORPSE                  96. ADDRESS OF CORPSE</p>		<p>97. NAME OF CORPSE                  98. ADDRESS OF CORPSE</p>	
<p>99. NAME OF CORPSE                  100. ADDRESS OF CORPSE</p>		<p>101. NAME OF CORPSE                  102. ADDRESS OF CORPSE</p>	

BUREAU V. S.

JUN 24 1957

RECEIVED

5975

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>32 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
				d. STREET ADDRESS <b>WHITEHALL ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>SKIPWITH</b> Middle <b>CANNELL</b> Last <b>CANNELL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 22, 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ECONOMIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>INTERSTATE COMMERCE RESEARCH SECTION</b>			
11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>SKIPWITH CANNELL, SR.</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PHARYNX WITH METASTASES</b> <b>148x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA BILATERAL</b>							
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>MAY 14, 1957</b> , to <b>JUNE 15, 1957</b> , and that death occurred at <b>10:18 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6-16-57</b> ACTUAL SIGNATURE <b>Armen Bogosian</b> M.D. <b>6-16-57</b> PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN</b> M.D. <b>FORT HOWARD, MARYLAND</b> <b>6-16-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight, Inc.</b> <b>6009 Harford Road, Baltimore, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>Jawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten and printed text.

BUREAU V. S.

JUN 24 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05966

5976

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>73 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STOCKTON</b> <b>23 X 22</b>	
4. DATE OF DEATH First Middle Last <b>HARRY S CANNON</b>		4. DATE OF DEATH Month Day Year <b>JUNE 16 19 57</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 3, 1921</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OYSTER SHUCKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OYSTER PACKING &amp; SHIPPING COMPANY</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ASBURY CANNON</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE KNOX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR, GLIOBLASTOMA MULTIFORME</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>37X</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MALIGNANT HYPERTENSION WITH CEREBROVASCULAR ACCIDENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>APRIL 3</b> , 19 <b>57</b> , to <b>JUNE 16</b> , 19 <b>57</b> , and that death occurred at <b>7:12 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/17/57</b> ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/17/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hornstown Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>HOENSTOWN, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Worden &amp; Savage Funeral Home, New Church, Virginia</b>		24a. REC'D BY REGISTRAR <b>6/17/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Furr</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DECEASED

DATE OF DEATH

PLACE OF DEATH

RESIDENT

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

AGE

SEX

CAREER

RELIGION

EDUCATION

DATE OF DEATH

PLACE OF DEATH

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU V. 1

JUN 18 1957

RECEIVED

5977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>516 N. Rolling Road</b>				d. STREET ADDRESS <b>516 N. Rolling Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>W.</b> Last <b>Carr</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 16, 1881</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George R. Carr</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice Daniels</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Raymond E. Carr 1525 Linden Ave., (27)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1</b> DUE TO <b>① Acute &amp; Chronic Congestive Heart Failure.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>② cor Pulmonale.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>526 Bronchitis &amp; Emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6/17/57</b>	
20f. (City or town) <b>1303 Frederick Rd</b>				(County)		(State)	
21. I certify that I attended the deceased from <b>6/1/57</b> to <b>6/17/57</b> , that I last saw the deceased alive on <b>6/1/57</b> , 19 <b>57</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Mc Grath</b>				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 Md</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Mc Grath</b>				DATE SIGNED <b>6/18/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b>				ADDRESS <b>3767 W. North Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Deed Smith</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JUN 20 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05968

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2718 Frederick Road</b>				d. STREET ADDRESS <b>1 2718 Frederick Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>MILDRED AUGUSTA<sup>Middle</sup> CAVEY</b> <b>Mildred Cavey</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>4</b> Year <b>1957</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 4, 1904</b>		<b>9. AGE</b> (In years last birthday) <b>52 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Drug Store</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Howard County, Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b>  	
<b>13. FATHER'S NAME</b> <b>Roswell Cavey</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Lilly Cogle</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>216-10-8027</b>		<b>17. INFORMANT</b> Address <b>Margaret L. Cavey, 24 W. Loch Lane, Richmond, Va</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <b>330X Massive subarachnoid hemorrhage due to rupture of aneurysm of right anterior cerebral artery</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) _____         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH    </div> </div>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)						
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <i>William V. Lovitt, Jr.</i>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <b>William V. Lovitt, Jr., M.D.</b>						<b>DATE SIGNED</b> <b>6/6/57</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>22b. DATE THEREOF</b> <b>6-7-57</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Meadowridge Memorial</b>			<b>22d. LOCATION (City, town, or county)</b> (State) <b>Dorsey, Md</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Frank C. Higinbotham, Ellicott City, Md.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 10 '57</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>West</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, removal or removal.

MAKING STATEMENT OF HEALTH - BATHING IS  
AND CAN EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Occupation		Cause of Death	
Residence		Manner of Death	
Signature of Examiner		Signature of Deceased	
Date of Examination		Date of Statement	

BUREAU V. S.

JUN 10 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05969

5979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3V01.4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING-GROVE ST. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>F.</b> Last <b>CHAMBERLAIN</b>				4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-1902</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CHAMBERLAIN</b>				14. MOTHER'S MAIDEN NAME <b>DORA LASSNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOPHIE CHAMBERLAIN</b> Address <b>6 S. CASTLE AVE. BALTO.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 13, 1937</b> , to <b>June 1, 1957</b> , that I last saw the deceased alive on <b>1949</b> , and that death occurred at <b>6:25 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William N. Karn, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>6-1-57</b>			
PHYSICIAN'S NAME (Type) <b>William N. Karn, Jr. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>June 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert B. M. Walters</b> ADDRESS <b>Pratt &amp; Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 3 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Robert B. M. Walters</b>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF CHIEF CLERK</p>		<p>19. SIGNATURE OF ASSISTANT CLERK</p>		<p>20. SIGNATURE OF DEPUTY CLERK</p>	
<p>21. SIGNATURE OF DEPUTY CLERK</p>		<p>22. SIGNATURE OF DEPUTY CLERK</p>		<p>23. SIGNATURE OF DEPUTY CLERK</p>		<p>24. SIGNATURE OF DEPUTY CLERK</p>	
<p>25. SIGNATURE OF DEPUTY CLERK</p>		<p>26. SIGNATURE OF DEPUTY CLERK</p>		<p>27. SIGNATURE OF DEPUTY CLERK</p>		<p>28. SIGNATURE OF DEPUTY CLERK</p>	
<p>29. SIGNATURE OF DEPUTY CLERK</p>		<p>30. SIGNATURE OF DEPUTY CLERK</p>		<p>31. SIGNATURE OF DEPUTY CLERK</p>		<p>32. SIGNATURE OF DEPUTY CLERK</p>	
<p>33. SIGNATURE OF DEPUTY CLERK</p>		<p>34. SIGNATURE OF DEPUTY CLERK</p>		<p>35. SIGNATURE OF DEPUTY CLERK</p>		<p>36. SIGNATURE OF DEPUTY CLERK</p>	
<p>37. SIGNATURE OF DEPUTY CLERK</p>		<p>38. SIGNATURE OF DEPUTY CLERK</p>		<p>39. SIGNATURE OF DEPUTY CLERK</p>		<p>40. SIGNATURE OF DEPUTY CLERK</p>	
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<p>45. SIGNATURE OF DEPUTY CLERK</p>		<p>46. SIGNATURE OF DEPUTY CLERK</p>		<p>47. SIGNATURE OF DEPUTY CLERK</p>		<p>48. SIGNATURE OF DEPUTY CLERK</p>	
<p>49. SIGNATURE OF DEPUTY CLERK</p>		<p>50. SIGNATURE OF DEPUTY CLERK</p>		<p>51. SIGNATURE OF DEPUTY CLERK</p>		<p>52. SIGNATURE OF DEPUTY CLERK</p>	
<p>53. SIGNATURE OF DEPUTY CLERK</p>		<p>54. SIGNATURE OF DEPUTY CLERK</p>		<p>55. SIGNATURE OF DEPUTY CLERK</p>		<p>56. SIGNATURE OF DEPUTY CLERK</p>	
<p>57. SIGNATURE OF DEPUTY CLERK</p>		<p>58. SIGNATURE OF DEPUTY CLERK</p>		<p>59. SIGNATURE OF DEPUTY CLERK</p>		<p>60. SIGNATURE OF DEPUTY CLERK</p>	
<p>61. SIGNATURE OF DEPUTY CLERK</p>		<p>62. SIGNATURE OF DEPUTY CLERK</p>		<p>63. SIGNATURE OF DEPUTY CLERK</p>		<p>64. SIGNATURE OF DEPUTY CLERK</p>	
<p>65. SIGNATURE OF DEPUTY CLERK</p>		<p>66. SIGNATURE OF DEPUTY CLERK</p>		<p>67. SIGNATURE OF DEPUTY CLERK</p>		<p>68. SIGNATURE OF DEPUTY CLERK</p>	
<p>69. SIGNATURE OF DEPUTY CLERK</p>		<p>70. SIGNATURE OF DEPUTY CLERK</p>		<p>71. SIGNATURE OF DEPUTY CLERK</p>		<p>72. SIGNATURE OF DEPUTY CLERK</p>	
<p>73. SIGNATURE OF DEPUTY CLERK</p>		<p>74. SIGNATURE OF DEPUTY CLERK</p>		<p>75. SIGNATURE OF DEPUTY CLERK</p>		<p>76. SIGNATURE OF DEPUTY CLERK</p>	
<p>77. SIGNATURE OF DEPUTY CLERK</p>		<p>78. SIGNATURE OF DEPUTY CLERK</p>		<p>79. SIGNATURE OF DEPUTY CLERK</p>		<p>80. SIGNATURE OF DEPUTY CLERK</p>	
<p>81. SIGNATURE OF DEPUTY CLERK</p>		<p>82. SIGNATURE OF DEPUTY CLERK</p>		<p>83. SIGNATURE OF DEPUTY CLERK</p>		<p>84. SIGNATURE OF DEPUTY CLERK</p>	
<p>85. SIGNATURE OF DEPUTY CLERK</p>		<p>86. SIGNATURE OF DEPUTY CLERK</p>		<p>87. SIGNATURE OF DEPUTY CLERK</p>		<p>88. SIGNATURE OF DEPUTY CLERK</p>	
<p>89. SIGNATURE OF DEPUTY CLERK</p>		<p>90. SIGNATURE OF DEPUTY CLERK</p>		<p>91. SIGNATURE OF DEPUTY CLERK</p>		<p>92. SIGNATURE OF DEPUTY CLERK</p>	
<p>93. SIGNATURE OF DEPUTY CLERK</p>		<p>94. SIGNATURE OF DEPUTY CLERK</p>		<p>95. SIGNATURE OF DEPUTY CLERK</p>		<p>96. SIGNATURE OF DEPUTY CLERK</p>	
<p>97. SIGNATURE OF DEPUTY CLERK</p>		<p>98. SIGNATURE OF DEPUTY CLERK</p>		<p>99. SIGNATURE OF DEPUTY CLERK</p>		<p>100. SIGNATURE OF DEPUTY CLERK</p>	

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5980

## CERTIFICATE OF DEATH

Reg. Dist. No.

05970

33

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Reisterstown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Delia</b> Middle <b>Chenoweth</b> Last <b>Chenoweth</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1877</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dundalk, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Boyle</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. A. Paul Chenoweth, Reisterstown Rd.</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumococcosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ga. of stomach</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> 19 p. m. <b>none</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>7-24-44</b> , 19____, to <b>6-26-57</b> , 19____, that I last saw the deceased alive on <b>6-26-57</b> , 19____, and that death occurred at <b>11:45 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>6-28-57</b>			
ACTUAL SIGNATURE <b>D.D. Caples</b>		PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrison Forrest, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Hicksville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 1 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary Eline</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5981

CERTIFICATE OF DEATH

05971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>326 East 20th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>T.</b> Last <b>CHENOWETH</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 11, 1894</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Repairman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Towson, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Chenoweth</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>705-10-8819</b>			
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COR PULMONALE</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.3</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>VA</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>8:25 AM June 18, 1957</b> to <b>1:05 PM, June 19, 1957</b> and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Armen Bogosian</b>				DATE SIGNED <b>6/19/57</b>			
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M. D.</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>				24a. REC'D BY REGISTRAR <b>Wm Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	



**BUREAU V. S.**

JUN 24 1957

RECEIVED





# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1915

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RESIDENCE

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

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BUREAU V. S.

JUN 10 1915

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5983

## CERTIFICATE OF DEATH

05973  
44

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA POST OFFICE</b> 02x22 ✓	
d. STREET ADDRESS <b>OUTING AVE. &amp; SHORE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L.</b> Last <b>CHRISTIAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 10, 1905</b>
9. AGE (In years lost birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EDITOR &amp; PUBLISHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MAGAZINE FIRM</b>	
11. BIRTHPLACE (State or foreign country) <b>RICHMOND, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES M. CHRISTIAN</b>		14. MOTHER'S MAIDEN NAME <b>GRACE CHRISTION</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>214-05-1406</b>	
17. INFORMANT <b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKIN'S DISEASE</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASCITES</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 19 57</b> , to <b>June 29, 19 57</b> and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 6/30/57</b>			
ACTUAL SIGNATURE <b>Armen Bogosian</b>		M.D. <b>Veterans Administration Hospital</b>	
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M. D.</b>		<b>Fort Howard, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorriane Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>		ADDRESS <b>SINGLETON FUNERAL HOME, Grain Hg, Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farkey</b>	

BU

2 JUL 1957

RECEIVED

5984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b> <b>3V01-4</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b> <b>329 Harlem Avenue</b>				d. STREET ADDRESS <b>2326 Aiken Street</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>S.</b> Last <b>Clark</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1888</b>		9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist (Ret'd)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Dry Dock Co.,</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Spooner Clark</b>				14. MOTHER'S MAIDEN NAME <b>Giorgianna McCormick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Wilbur F. Clark, 2326 Aiken Street, Baltimore 18</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction 6 Hrs B.P. unknown</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1, 1957</b> to <b>June 6, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>CLIFFE RATLIFF, JR.</b> <b>4605 EDMONDSON AVE.</b> <b>6/7/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>JUN 7 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Clark</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint, illegible markings.

**RECEIVED**  
JUN 10 1957  
**BUREAU V. S.**



5985

## CERTIFICATE OF DEATH

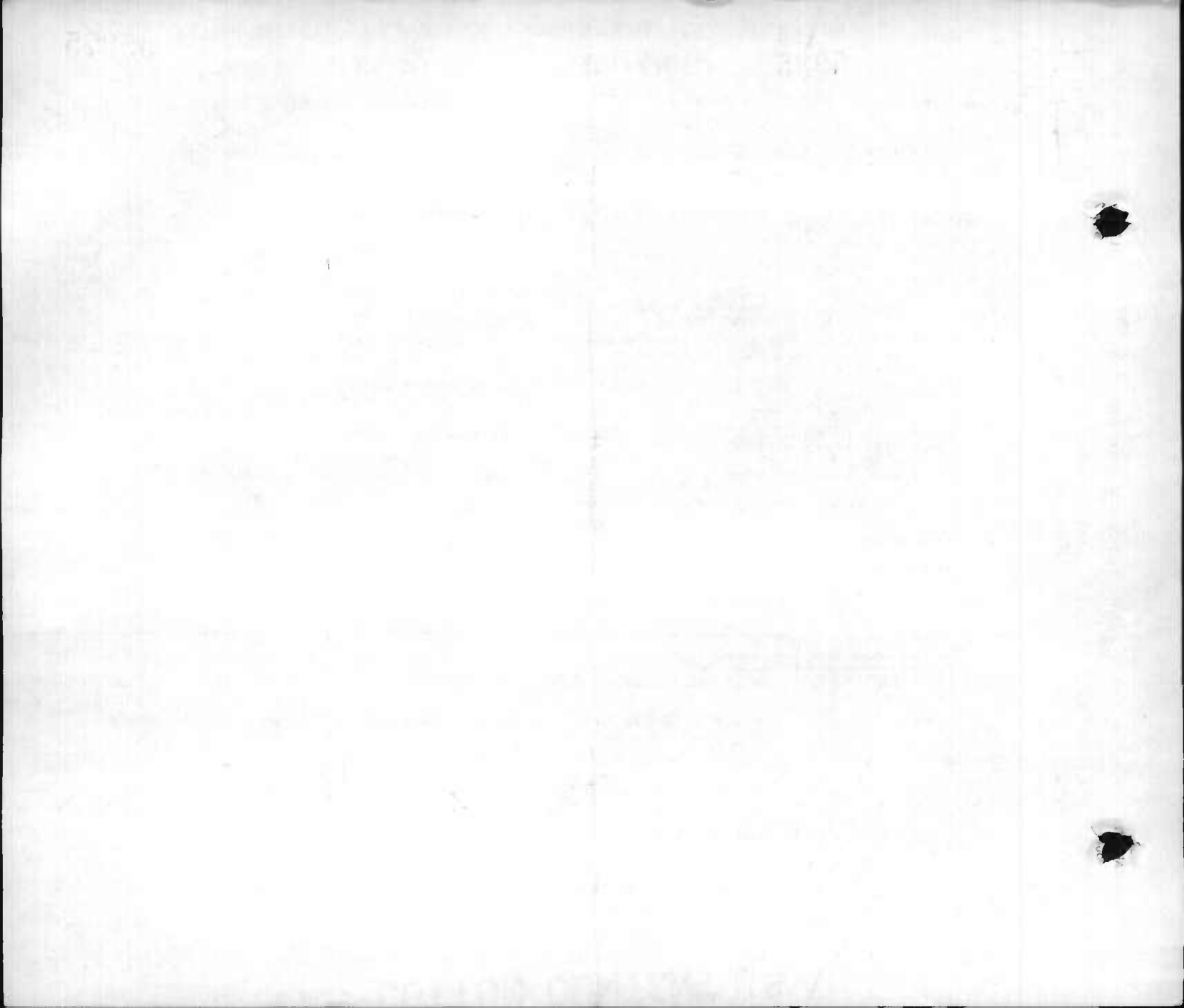
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Baltimore</i>	LENGTH OF STAY (in this place) <i>1 yr</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2616 Proctor Lane</i>		STREET ADDRESS (If rural give location) <i>2616 Proctor La</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Mary</i> (Middle) <i>Augusta</i> (Last) <i>Clark</i>		(Month) <i>June</i> (Day) <i>7</i> (Year) <i>1957</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid.</i>	8. DATE OF BIRTH: <i>Oct 15 1865</i>
9. AGE last birthday: <i>92</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Ret'd</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	11. BIRTHPLACE (State or foreign country): <i>Balto, Md.</i>
12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>			
13. FATHER'S NAME: <i>John O. Peterson</i>		14. MOTHER'S MAIDEN NAME: <i>Margaretta Mueller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: _____	
17. INFORMANT & ADDRESS: <i>Daughter 2616 Proctor La.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <i>Senility with Heart Failure</i>			
Antecedent causes (s) (b) <i>Failure</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>			
19a. DATE OF OPERATION: <i>None</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i> <input type="checkbox"/>			
21. ACCIDENT (Specify) <i>SUICIDE</i>	PLACE (Home, farm, factory, street, OF office-bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 19 <i>54</i> , to <i>July</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 1, 1957</i> and that death occurred at <i>8:30 pm</i> from the causes and on the date stated above. SIGNATURE <i>Frank C. Lankford M.D.</i> ADDRESS <i>9005 Harford Rd Balto Md 6/7/57</i> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>June 10, 1957</i>	NAME OF CEMETERY OR CREMATORY <i>Wagh Church Cemetery</i>	LOCATION (City, town, or county) (State) <i>Balto Co. Md</i>
DATE REC'D BY LOCAL REGISTRAR <i>June 8, 1957</i>	REGISTRAR'S SIGNATURE <i>R.W.</i>	24. FUNERAL DIRECTOR <i>CHAS F. LUNAS 6802 Harford Rd</i> ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5937

## CERTIFICATE OF DEATH

05976

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>53</b> <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1907 Tyler Rd.</b>				d. STREET ADDRESS <b>1907 Tyler Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L.</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1890</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>Savanah Carter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Erma M. Clark - 1907 Tyler Rd., Dundalk, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Cardiac of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 1956</b> to <b>June 29, 1957</b> , that I last saw the deceased alive on <b>June 27, 1957</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.				DATE SIGNED <b>6:00 morning in bond</b>			
PHYSICIAN'S NAME (Type) <b>M. B. DAVIS M.D.</b>				ADDRESS (Street, city or town, state) <b>Dundalk - 22 md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Tiekner</b>				24a. REC'D BY REGISTRAR DATE <b>7/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>Thos. E. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		Natural		Heart Disease		Home		10:00 AM		J. Smith		A. Jones	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Death		Date of Burial		Place of Burial		Name of Burial Place		Name of Minister		Name of Undertaker		Name of Funeral Home	
Teacher		Married		None		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Cemetery		St. John's Church		Rev. Mr. Brown		Mr. White		Funeral Home	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Undertaker		Signature of Funeral Home		Signature of Burial Place		Signature of Name of Burial Place		Signature of Name of Minister		Signature of Name of Undertaker		Signature of Name of Funeral Home		Signature of Name of Burial Place	

BUREAU V. S.

JUL 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b <b>Approx. 2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Parkville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>/8804 Glenroy Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Burgess</b> Last <b>Clubb</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7/6/1899</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>William Clubb</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rutue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>214-16-1224</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skull Fracture</b> DUE TO <b>Fracture right ankle</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture both knees</b> (c) <b>Mental Depression</b> DUE TO <b>Pulmonary Tuberculosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped from 8th floor Hospital window</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9:30</b> o. m. <b>6 25 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mt. Wilson Hosp.</b>		20f. (City or town) (County) (State) <b>Mt. Wilson Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b> EXAMINER'S NAME (Type) <b>D.D. CAPLES, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-28-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST PETER'S CEM</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight Inc</b>				ADDRESS <b>6009 HARFORD RD</b>		24a. REC'D BY REGISTRAR DATE <b>6/26/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Donathy Russell</b>	

DATE SIGNED  
**6/25/57**

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.

BUREAU V. S.

JUN 27 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

Item 20 Film 217 6-28-57 5987										STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05978									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Texas</u>					c. LENGTH OF STAY IN 1b <u>hite</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Texas, Cockeysville</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Padonia Rd.</u>										d. STREET ADDRESS <u>York Rd.</u>																			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Glenn</u> Last <u>Cofiell</u>										4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1957</u>																			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-47</u>				9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min. <u>19</u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>					11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>Carroll E. Cofiell, Sr.</u>										14. MOTHER'S MAIDEN NAME <u>Annabelle Ensor</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>none</u>					17. INFORMANT <u>Carroll E. Cofiell, Sr.</u> Address <u>Cockeysville, Md.</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u></u>															INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped off edge of quarry into water &amp; failed to reappear</u> <u>Found beneath shelf 10ft below surface of water.</u>																								
20c. TIME OF INJURY Month, Day, Year <u>6-16-57</u> Hour <u>4:30</u> a. m. <u>6</u> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lindsays Quarry</u>					20f. (City or town) <u>Timonium</u> (County) <u>Md.</u> (State) <u>Md.</u>														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																													
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED <u>6/17/57</u>									
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>6-19-57</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock</u>					22d. LOCATION (City, town, or county) <u>Butler</u> (State) <u>Maryland</u>														
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service</u> <u>2. Scott Brooks</u>										ADDRESS <u>622 York Rd.</u> <u>Towson 4, Md.</u>										24a. REC'D BY REGISTRAR <u>JUN 18 '57</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

JUN 18 1957

RECEIVED  
JUN 18 1957

059798

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Florida</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Miami 48x-3</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>601 Fairway Drive</i>				d. STREET ADDRESS <i>1601 N.E. 109th Street</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Audrey A. Cofran</i>				4. DATE OF DEATH Month Day Year <i>June 2nd 19 57</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 14, 1910</i>	
9. AGE (In years lost birthday) yrs. <i>46</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beautician</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry V. Ardisson</i>				14. MOTHER'S MAIDEN NAME <i>Lillie Proctor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-01-4704</i>		17. INFORMANT Address <i>Mr. Edward L. Cofran, 601 Fairway Drive</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>1999</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma - primary site unknown</i> DUE TO (c) <i>Metastatic Adenocarcinoma of Brain, spine &amp; Thorax</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 months</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491x</i> <i>Neuraplegia (right)</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 28, 1957</i> to <i>June 2nd, 1957</i> , that I last saw the deceased alive on <i>June 2nd, 1957</i> , and that death occurred at <i>4 P. M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Samuel B. Wolfe</i>				DATE SIGNED <i>6/3/1957</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Samuel B. Wolfe</i>				ADDRESS (Street, city or town, state) <i>1331 East North Avenue</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/5/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #1411</i>		24a. REC'D BY REGISTRAR <i>DATE</i> <i>10 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Malik Grayson</i>			

# DEPARTMENT OF HEALTH - BALTIMORE 18 CERTIFICATE OF DEATH

BUREAU V. S.

JUN 10 1957

RECEIVED

5989

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4602 Ridgeway Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Mae</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clayton Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Annie Shaeffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-7934</u>	
17. INFORMANT <u>Mr. Orville Cooper</u>		Address <u>4602 Ridgeway Ave. 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X Carcinoma of Stomach</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1949</u> , to <u>June 15, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max R. English</u> M.D.		ADDRESS (Street, city or town, state) <u>5713 Belair Rd. Baltimore 6 Md.</u>	
DATE SIGNED <u>6-17-57</u>			
PHYSICIAN'S NAME (Type) <u>Max R. English M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUN 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Max L. Rappaport</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>June 15, 1957</i>		6. PLACE OF DEATH <i>Home</i>	
7. TIME OF DEATH <i>10:30 AM</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		14. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
15. SIGNATURE OF CORONER <i>John Doe</i>		16. SIGNATURE OF JURY <i>John Doe</i>	
17. SIGNATURE OF JUDGE <i>John Doe</i>		18. SIGNATURE OF CLERK <i>John Doe</i>	
19. SIGNATURE OF SHERIFF <i>John Doe</i>		20. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
21. SIGNATURE OF DISTRICT ATTORNEY <i>John Doe</i>		22. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
23. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		24. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
25. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		26. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
27. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		28. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
29. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		30. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
31. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		32. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
33. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		34. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
35. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		36. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
37. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		38. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
39. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		40. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
41. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		42. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
43. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		44. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
45. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		46. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
47. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		48. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
49. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		50. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
51. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		52. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
53. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		54. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
55. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		56. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
57. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		58. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
59. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		60. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
61. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		62. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
63. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		64. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
65. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		66. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
67. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		68. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
69. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		70. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
71. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		72. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
73. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		74. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
75. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		76. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
77. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		78. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
79. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		80. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
81. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		82. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
83. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		84. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
85. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		86. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
87. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		88. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
89. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		90. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
91. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		92. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
93. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		94. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
95. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		96. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	
97. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		98. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
99. SIGNATURE OF COUNTY COMMISSIONER <i>John Doe</i>		100. SIGNATURE OF COUNTY TREASURER <i>John Doe</i>	

RECEIVED  
JUN 18 1957  
BUREAU V. E.



5990

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>54</u> <u>ESSEX</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904 GARDEN DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERTA L CORNS</u>				4. DATE OF DEATH Month Day Year <u>JUNE 5 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14-1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>			
13. FATHER'S NAME <u>DUVAL</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>MILTON D. CORNS SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart failure</u> DUE TO (c) <u>2 1/2 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>Auricular fibrillation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9 1957</u> to <u>June 1 1957</u> , that I last saw the deceased alive on <u>June 1 1957</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene C. Baumann M.D.</u>				ADDRESS (Street, city or town, state) <u>413 Eastern Ave. Essex, Md.</u> DATE SIGNED <u>6/8/1957</u>			
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				ADDRESS <u>418 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>Edith Huie</u>	
				DATE <u>JUN 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Huie</u>	

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5991

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balt. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>52 days</b>				18 301-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>2413 Maryland Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Robert</b> First		<b>Ellsworth</b> Middle		<b>Cox</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Structural Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Texas, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Wm. Cox</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-577</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-22-1957</b> , to <b>6-13-1957</b> , that I last saw the deceased alive on <b>June 12-1957</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>		<b>6-13-57</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>June 17-1957</b>		<b>Korname Ok</b>		<b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<b>Frank X Setty</b>		<b>814 W. 6 St Baltimore</b>		<b>JUN 17 1957</b>		<b>Joseph Newell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is mostly blank with some faint handwriting.

BUREAU V. E.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5938

05983 4  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Turners Station</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>612 Peach Orchard Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beulah</u> First <u>Davis</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Goucher College</u>	
11. BIRTHPLACE (State or foreign country) <u>Darlington, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Leslie Davis</u> Address <u>612 Peach Orchard Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (c), stating the underlying cause lost. DUE TO (c) <u>Smear</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wellsville, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	
ADDRESS <u>802 Madison Avenue, Baltimore 1, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 27 1957</u>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		DATE OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
PRINTED NAME OF MEDICAL EXAMINER [Faint text]		PRINTED NAME OF WITNESS [Faint text]		PRINTED NAME OF CORONER [Faint text]	
ADDRESS OF MEDICAL EXAMINER [Faint text]		ADDRESS OF WITNESS [Faint text]		ADDRESS OF CORONER [Faint text]	
CITY OF MEDICAL EXAMINER [Faint text]		CITY OF WITNESS [Faint text]		CITY OF CORONER [Faint text]	
STATE OF MEDICAL EXAMINER [Faint text]		STATE OF WITNESS [Faint text]		STATE OF CORONER [Faint text]	
COUNTY OF MEDICAL EXAMINER [Faint text]		COUNTY OF WITNESS [Faint text]		COUNTY OF CORONER [Faint text]	
ZIP CODE OF MEDICAL EXAMINER [Faint text]		ZIP CODE OF WITNESS [Faint text]		ZIP CODE OF CORONER [Faint text]	

RECEIVED  
 JUN 27 1967  
 BUREAU V. 1



5992

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hood Convalescent Home</u> <u>5313 Edmondson Avenue</u>		d. STREET ADDRESS <u>3609 Old York Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Webb</u> Last <u>Degenhard</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24, 1883</u>
9. AGE (In years last birthday) yrs. <u>74</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. L. Vogle, 373 Evesham Avenue, Baltimore 12</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure - Chronic</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD - marked</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous CVA - Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1957</u> , to <u>June 25, 1957</u> , that I last saw the deceased alive on <u>June 25, 1957</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor F. Long</u> M.D.		ADDRESS (Street, city or town, state) <u>Catonsville, Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>6/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUN 27 57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5993

CERTIFICATE OF DEATH

0598538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7532 Bellona Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>Helen R.</b> Last <b>Denbow</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1914</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William F. McKewen</b>				14. MOTHER'S MAIDEN NAME <b>Helen Roddy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>David Denbow</b>				Address <b>7532 Bellona Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Fibrillation</b> (c) <b>Rheumatic Heart Disease</b> <b>416X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>12 1/2 hrs.</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>OCT 48</b> to <b>June 28, 1957</b> , that I last saw the deceased alive on <b>June 26, 1957</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ADDRESS (Street, city or town, state) <b>2501 York Rd Baltimore Md</b>			
DATE SIGNED <b>6/29/57</b>				PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b> <b>101510 #4 M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. Evans &amp; Son</b>				ADDRESS <b>118 W. Mt. Royal Ave</b>		24a. REC'D BY REGISTRAR <b>2</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>				DATE <b>2 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 2 70

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

5994

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MARYLAND TRAINING School Boys</b>		e. STREET ADDRESS <b>Baltimore 3018 Glenmore ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Chris</b> Middle <b>Z</b> Last <b>DiMetri</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Zacharias</b>		14. MOTHER'S MAIDEN NAME <b>Pavlopoulos</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of vomitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Struck by lightning</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by lightning</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>6/25/ 19 57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lambros Inc. 440 E. North Ave.</b>		24. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

4293

1957 I 777

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5995

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 3Y01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>832 W. 34<sup>th</sup> ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eddie Alfred Dix</u>		4. DATE OF DEATH Month Day Year <u>JUNE 15 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/20</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS + ELECTRIC</u>	
11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>TANDY DIX</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>168-142552</u>	
17. INFORMANT <u>EVELYN L. Dix</u>		Address <u>832 W. 34<sup>th</sup> ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck concrete Culvert - Steering Wheel Crushed Chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>6/15 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>PARKTON BALTO. MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louaine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin B. Donovan</u>		ADDRESS <u>3818 Roland Ave</u>	
24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JUN 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

5996

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1c, 8, 9, Film G217 6-26-57 et

05988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti ore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>103 S. Monroe St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Karalina</u> Middle <u>Helen</u> Last <u>Drusutis</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>65 9</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-18-0994</u>	
17. INFORMANT <u>Mrs. Augania Alvey, 1201 Carroll St., Balto. 30</u>		Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular disease</u> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>getting out of bed on 5-10-57.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9:00</u> <u>PM</u> <u>5-10</u> <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		DATE SIGNED <u>6-18-57</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 20 '57</u>	
ADDRESS <u>St</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Seabach</u>	

2928

BUREAU V. S.

JUN 20 1957

RECEIVED

5997

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>509 Old Home Road</i>		d. STREET ADDRESS <i>1 509 Old Home Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Margaret J. Duvall</i>		4. DATE OF DEATH <i>June 17th 19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 15, 1878</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Peter Smith</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Keefer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. John Duvall, 509 Old Home Road #6</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>382X Multiple Cerebral Thromboses</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> 19 to <i>June</i> 1957, that I last saw the deceased alive on <i>June 14</i> 1957, and that death occurred at <i>6:00 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Loy M. Zimmerman</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>3202 Harford Road Balto Md 6/17/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Loy M. Zimmerman</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/20/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #18</i>		24a. REC'D BY REGISTRAR DATE <i>6/18/57</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. A. L. Rejzender</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 19 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05990

5998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>54 Oella Avenue</b>		d. STREET ADDRESS <b>54 Oella Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HAZEL</b> Last <b>EDMONSTON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spooler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. East</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Dailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-6347</b>	
17. INFORMANT <b>Mrs. Helen Woode</b>		Address <b>54 Oella Avenue Oella, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Degenerative Myocarditis</b> (c) <b>Generalized Arteriosclerosis with Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>447X</b> <b>Hemiplegic Rt. old</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2, 1956</b> , to <b>6/2/57</b> , that I last saw the deceased alive on <b>6/2/57</b> , 19 <b>57</b> , and that death occurred at <b>9:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.E. Mc Grath</b>		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 Md</b>	
PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath</b>		DATE SIGNED <b>6/2/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 5, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>d. H. H. H. H.</b>	

BUREAU V. 3

1957 6 JUN

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05991

5993

## CERTIFICATE OF DEATH

Item 9 FilmG218 7-18-57 et

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>52 Winters Lane</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>GARY</b> (Middle) <b>W.</b> (Last) <b>FIELDS</b>	4. DATE OF DEATH	(Month) <b>Jun</b> (Day) <b>16</b> (Year) <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec 7, 1891</b> 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Larkin Fields</b>		14. MOTHER'S MAIDEN NAME <b>Marie Holland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mrs. Rosa Fields 52 Winters La.</b>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <b>443X Hypertension Cardiac Decon</b>			<b>2 yrs</b>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Arteriosclerosis</b>			
(c) 4500			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 30</b> , 1956, to <b>June 16</b> , 1957, that I last saw the deceased alive on <b>June 17</b> , 1957 and that death occurred at <b>4</b> <b>PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>John W. [Signature]</b>		DATE SIGNED <b>June 27, 1957</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-20-57</b>	
NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>		LOCATION (City, town, or county) <b>Catonsville, Md.</b>	
DATE REC'D BY LOCAL REG. <b>6 JUN 20 1957</b>		FUNERAL DIRECTOR <b>Mrs. [Signature]</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1957

BUREAU V. S.

5939

## CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Dundalk 53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2057 Inverton Road</u>				d. STREET ADDRESS <u>2057 Inverton Road-Balto.22, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>R.</u> Last <u>FITZELL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1918</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Improvements</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Richard Fitzell</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-09-4320</u>			
17. INFORMANT <u>Mr. John Richard Fitzell-2057 Inverton Road-#22</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Glomerulo-Neph</u> <u>590X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>590X</u> DUE TO (c) <u>590X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-5</u> , 19 <u>55</u> , to <u>6-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack C Collins</u> M.D. <u>2 Kingship R</u>				ADDRESS (Street, city or town, state) <u>Baltimore 22 Md</u>			
DATE SIGNED <u>6-10-55</u>							
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichner &amp; Sons North &amp; N. Ave</u>				24a. REC'D BY REGISTRAR <u>6/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Tichner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

JUN 13 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

6000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0599344  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>3801-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Dispensary</b>		d. STREET ADDRESS <b>2802 Belmont Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>(NMI)</b> Last <b>Fitzgerald</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Crewe, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Pryor Fitzgerald</b>		14. MOTHER'S MAIDEN NAME <b>Martha Oliver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Addie Fitzgerald</b>		Address <b>2802 Belmont Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-19-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 June '57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Gibson, Jr.</b>		ADDRESS <b>1631 Druid Hill Ave.</b>	
24a. REC'D BY REGISTRAR <b>DATE 6/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>Sawson, L. H.</b>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		35		M		W		JUN 24 1957	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY	
1000 N. ST.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION	
BOSTON, MASS.		MYOCARDIAL INFARCTION				CHOLESTEROL		DIABETES	
APARTMENT 2		AT HOME				SMOKING		ALCOHOL	
FAMILY PHYSICIAN		HISTORICAL PHYSICIAN		PATHOLOGICAL PHYSICIAN		FORENSIC PHYSICIAN		MORPHOLOGICAL PHYSICIAN	
DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES	
DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		SIGNATURE OF PHYSICIAN		SIGNATURE OF PATHOLOGIST	
JUN 24 1957		1000 N. ST.		J. J. JONES		J. J. JONES		J. J. JONES	
BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.	

BUREAU V. S.

JUN 24 1957

RECEIVED

Item 2 By phone Wm. Tickner 6-26-57 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2mths15dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>411 Pontiac St.</u> <u>15 Maryland Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Mary</u> Middle <u>Margaretta</u> Last <u>Fitzjarrell</u>		4. DATE OF DEATH		Month <u>June</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1882</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>occupational therapist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>GEorge W. Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide H. Carver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>March 25</u> , 19 <u>57</u> , to <u>June 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>57</u> , and that death occurred at <u>10:45 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>6-19-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balt. 17</u>				24a. REC'D BY REGISTRAR <u>June 25 57</u>		24b. REGISTRAR'S SIGNATURE <u>Qu...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 26 1957

RECEIVED

6902

## CERTIFICATE OF DEATH

05995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>Andrews Air Force Base</b>			
3. NAME OF DECEASED (Type or print) First <b>Etta</b> Middle <b>Mae</b> Last <b>Chatham Foltz</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1879</b>	9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>John Chatham</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>57</b> to <b>June 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 14</b> , 19 <b>57</b> , and that death occurred at <b>9:50 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-14-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Williamsport, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRISTIAN F. H. Williamsport Pa</b> <b>Mac Nab + Son Catonsville Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 17 57</b>		24b. REGISTRAR'S SIGNATURE <b>Qu. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		USA		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JUN 17 1957		10:30 AM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH		SIGNATURE OF CEMETERY	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 3

JUN 17 1957

RECEIVED



## 6003 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>19 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>K.</b> Last <b>FORD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>	
11. BIRTHPLACE (State or foreign country) <b>Eastport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Ford</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>214-18-2704</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>262X</b> (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Arteriosclerosis, generalized. 2. Diabetes Mellitus. 3. Cerebral thrombosis, left, old.</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 31</b> , 19 <b>57</b> , to <b>June 19</b> , 19 <b>57</b> , and that death occurred at <b>10:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Armen Bogosian</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>6/20/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>6-24-57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National</b>			
22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>6/21/57</b>			
24b. REGISTRAR'S SIGNATURE <b>Jawson L. Farkey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED BY HEARSE TO: John Taylor &amp; Sons, Duke of Gloucester, Annapolis, Maryland

BUREAU V. S.

JUN 24 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6904

CERTIFICATE OF DEATH

Reg. Dist. No. 05997

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		d. STREET ADDRESS <b>1 242 Blakney Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>242 Blakney Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna C Forney</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>19</b> Hours <b>19</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel Henderson</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Considine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>212.16.3935-B</b>		17. INFORMANT <b>Mrs Edna Demarest 242 Blakney Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. <b>11</b> p. <b>11</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1957</b> to <b>June 15, 1957</b> , that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3508 Bank St., Baltimore 24, Md</b> DATE SIGNED <b>June 14, 1957</b>			
ACTUAL SIGNATURE <b>Joseph Robert Liberto</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOSEPH ROBERT LIBERTO</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUN 18 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		Boston, Mass.		Boston, Mass.		Heart Disease		Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		None		Jan 10, 1956		Jan 10, 1956		Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith	

**RECEIVED**  
JUN 18 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6005

CERTIFICATE OF DEATH

05998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 Carroll Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Marie</b> Last <b>Foster</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 57</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1896</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James J. Huster</b>		14. MOTHER'S MAIDEN NAME <b>Marie Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. August L. Foster, 9 Carroll Rd, Catonsv</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15</b> , 19 <b>57</b> , to <b>May 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 21</b> , 19 <b>57</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4508 Edmondson Village Balto. 29, Md.</b> ACTUAL SIGNATURE <b>D. C. MacLaughlin, M.D.</b> M.D. <b>4508 Edmondson Village Balto. 29, Md.</b> PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin, M.D.</b> <b>4508 Edmondson Village, Balto. 29, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 8/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>		24a. RECEIVED BY REGISTRAR <b>57</b> 24b. REGISTRAR'S SIGNATURE <b>W. L. Loughlin</b>	



CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		June 1, 1957	
Age		Sex	
45		Male	
Place of Birth		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Manner of Death	
Teacher		Natural	
Date of Burial		Place of Burial	
June 3, 1957		Catholic Cemetery	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. S.

JUN 10 1957

RECEIVED



6006

CERTIFICATE OF DEATH

0599938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>3215 Batavia Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Rosa A. Foster</i>		4. DATE OF DEATH <i>June 23rd, 1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1877</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Kroeger</i>		14. MOTHER'S MAIDEN NAME <i>Rose</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. William F. Foster, 3215 Batavia Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular hemorrhage</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>5 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 23, 1957</i> to <i>June 23, 1957</i> , that I last saw the deceased alive on <i>June 23, 1957</i> , and that death occurred at <i>9:45 pm</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert Mazer</i>		DATE SIGNED <i>6/24/57</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT MAZER</i>		<i>Baltimore 18 hrs</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/26/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>JUN 26 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF SHERIFF'S CLERK		20. SIGNATURE OF SHERIFF'S DEPUTY	
21. SIGNATURE OF SHERIFF'S DEPUTY		22. SIGNATURE OF SHERIFF'S DEPUTY		23. SIGNATURE OF SHERIFF'S DEPUTY		24. SIGNATURE OF SHERIFF'S DEPUTY		25. SIGNATURE OF SHERIFF'S DEPUTY	
26. SIGNATURE OF SHERIFF'S DEPUTY		27. SIGNATURE OF SHERIFF'S DEPUTY		28. SIGNATURE OF SHERIFF'S DEPUTY		29. SIGNATURE OF SHERIFF'S DEPUTY		30. SIGNATURE OF SHERIFF'S DEPUTY	
31. SIGNATURE OF SHERIFF'S DEPUTY		32. SIGNATURE OF SHERIFF'S DEPUTY		33. SIGNATURE OF SHERIFF'S DEPUTY		34. SIGNATURE OF SHERIFF'S DEPUTY		35. SIGNATURE OF SHERIFF'S DEPUTY	
36. SIGNATURE OF SHERIFF'S DEPUTY		37. SIGNATURE OF SHERIFF'S DEPUTY		38. SIGNATURE OF SHERIFF'S DEPUTY		39. SIGNATURE OF SHERIFF'S DEPUTY		40. SIGNATURE OF SHERIFF'S DEPUTY	
41. SIGNATURE OF SHERIFF'S DEPUTY		42. SIGNATURE OF SHERIFF'S DEPUTY		43. SIGNATURE OF SHERIFF'S DEPUTY		44. SIGNATURE OF SHERIFF'S DEPUTY		45. SIGNATURE OF SHERIFF'S DEPUTY	
46. SIGNATURE OF SHERIFF'S DEPUTY		47. SIGNATURE OF SHERIFF'S DEPUTY		48. SIGNATURE OF SHERIFF'S DEPUTY		49. SIGNATURE OF SHERIFF'S DEPUTY		50. SIGNATURE OF SHERIFF'S DEPUTY	
51. SIGNATURE OF SHERIFF'S DEPUTY		52. SIGNATURE OF SHERIFF'S DEPUTY		53. SIGNATURE OF SHERIFF'S DEPUTY		54. SIGNATURE OF SHERIFF'S DEPUTY		55. SIGNATURE OF SHERIFF'S DEPUTY	
56. SIGNATURE OF SHERIFF'S DEPUTY		57. SIGNATURE OF SHERIFF'S DEPUTY		58. SIGNATURE OF SHERIFF'S DEPUTY		59. SIGNATURE OF SHERIFF'S DEPUTY		60. SIGNATURE OF SHERIFF'S DEPUTY	
61. SIGNATURE OF SHERIFF'S DEPUTY		62. SIGNATURE OF SHERIFF'S DEPUTY		63. SIGNATURE OF SHERIFF'S DEPUTY		64. SIGNATURE OF SHERIFF'S DEPUTY		65. SIGNATURE OF SHERIFF'S DEPUTY	
66. SIGNATURE OF SHERIFF'S DEPUTY		67. SIGNATURE OF SHERIFF'S DEPUTY		68. SIGNATURE OF SHERIFF'S DEPUTY		69. SIGNATURE OF SHERIFF'S DEPUTY		70. SIGNATURE OF SHERIFF'S DEPUTY	
71. SIGNATURE OF SHERIFF'S DEPUTY		72. SIGNATURE OF SHERIFF'S DEPUTY		73. SIGNATURE OF SHERIFF'S DEPUTY		74. SIGNATURE OF SHERIFF'S DEPUTY		75. SIGNATURE OF SHERIFF'S DEPUTY	
76. SIGNATURE OF SHERIFF'S DEPUTY		77. SIGNATURE OF SHERIFF'S DEPUTY		78. SIGNATURE OF SHERIFF'S DEPUTY		79. SIGNATURE OF SHERIFF'S DEPUTY		80. SIGNATURE OF SHERIFF'S DEPUTY	
81. SIGNATURE OF SHERIFF'S DEPUTY		82. SIGNATURE OF SHERIFF'S DEPUTY		83. SIGNATURE OF SHERIFF'S DEPUTY		84. SIGNATURE OF SHERIFF'S DEPUTY		85. SIGNATURE OF SHERIFF'S DEPUTY	
86. SIGNATURE OF SHERIFF'S DEPUTY		87. SIGNATURE OF SHERIFF'S DEPUTY		88. SIGNATURE OF SHERIFF'S DEPUTY		89. SIGNATURE OF SHERIFF'S DEPUTY		90. SIGNATURE OF SHERIFF'S DEPUTY	
91. SIGNATURE OF SHERIFF'S DEPUTY		92. SIGNATURE OF SHERIFF'S DEPUTY		93. SIGNATURE OF SHERIFF'S DEPUTY		94. SIGNATURE OF SHERIFF'S DEPUTY		95. SIGNATURE OF SHERIFF'S DEPUTY	
96. SIGNATURE OF SHERIFF'S DEPUTY		97. SIGNATURE OF SHERIFF'S DEPUTY		98. SIGNATURE OF SHERIFF'S DEPUTY		99. SIGNATURE OF SHERIFF'S DEPUTY		100. SIGNATURE OF SHERIFF'S DEPUTY	

RECEIVED  
JUN 26 1957  
BUREAU V. S.

6007

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>				c. LENGTH OF STAY IN 1b <b>13x22</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>47 Oella Ave.</b>				d. STREET ADDRESS <b>Columbia Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle <b>ANNA</b> Last <b>GAMBER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Eli Becraft</b>				14. MOTHER'S MAIDEN NAME <b>Ida Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Erma Delawder, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - CV disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Syn-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1950</b> , to <b>June 13, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>6:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ellicott City, Md.</b> <b>6-13-57</b>							
ACTUAL SIGNATURE <b>Leon H. Kochman</b> M.D. <b>Ellicott City, Md.</b>				PHYSICIAN'S NAME (Type) <b>Leon H. Kochman</b> M.D. <b>Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>17 57</b>		24b. REGISTRAR'S SIGNATURE <b>Rufus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6908

## CERTIFICATE OF DEATH

Reg. Dist. No.

06908282

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr4mths 7days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood, Maryland (Leonardtwn) 18x02</b>		d. STREET ADDRESS <b>Hollywood, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oster</b> Middle <b>May</b> Last <b>Catton</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, ??</b>
9. AGE (In years last birthday) yrs. <b>68?</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 12</b> , 19 <b>54</b> , to <b>JUNE 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>JUNE 19</b> , 19 <b>57</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles Ward</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>DR. CHARLES WARD</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clark Mattingley</b>		24a. REC'D BY REGISTRAR <b>6/21/57</b>	
ADDRESS <b>Leonardtwn, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Harold K. Kowser</b>	

RECEIVED



6009

## CERTIFICATE OF DEATH

060021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO RURAL - ROCKDALE</u>			
c. LENGTH OF STAY IN 1b <u>3 YEARS</u>				d. STREET ADDRESS <u>1 3610 ROCKDALE TERRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3610 ROCKDALE TERRACE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ISABELLE</u> Last <u>GIEGAS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>19 57</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1878</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>19</u> Min. <u>57</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES GIEGAS</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. M. FARLAND</u>		Address <u>3610 ROCKDALE TERRACE BALTO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE - PULMONARY EDEMA</u> <u>444X</u> DUE TO (b) <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 19 57</u> to <u>JUNE 4, 19 57</u> , that I last saw the deceased alive on <u>JUNE 3, 19 57</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8204 LIBERTY RD BALTO 7, MD</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u>				ADDRESS <u>8204 LIBERTY RD, BALTO. 7, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 6, 1957</u>		<u>St. Clare Cemetery</u>		<u>North Baltimore, Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
<u>Charles Ramoreau - 4510 Liberty Heights Ave</u>				<u>BALTO</u>		<u>JUN 7 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - FORM ONE 10

100001

Page One of Two

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CEMETERY</p>	
<p>21. SIGNATURE OF CHURCH</p>		<p>22. SIGNATURE OF MINISTERS</p>	
<p>23. SIGNATURE OF CLERGY</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
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<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

RECEIVED  
JUN 7 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5945

## CERTIFICATE OF DEATH

06003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5616 Carville Ave</u>		d. STREET ADDRESS <u>5616 Carville Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Millard</u> Middle <u>E.</u> Last <u>Gilbert, Sr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1894</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ending Machine Proprietor, Own Business-- Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Denton Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>WIFE</u>	
17. INFORMANT <u>Mrs. Linda O. Gilbert, 5616 Carville Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNG &amp;</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTASIS BRAIN</u> DUE TO (c) <u>ACUTE PULMONARY EDEMA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>57</u> , to <u>6/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>57</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmondson Ave.</u>		PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D. BALTO. 28, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave</u>		24. REC'D BY REGISTRAR <u>1957</u> REGISTRAR'S SIGNATURE <u>Dr. M. Kuffner</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JUL 1 1957	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
MARRIAGE		RELATIONSHIP	
Single		Son of	
BIRTH DATE		BIRTH PLACE	
JUL 1 1922		Memphis, Tennessee	
OCCUPATION		EDUCATION	
Attorney		High School	
PLACE OF DEATH		CAUSE OF DEATH	
Baltimore, Maryland		Suicide	
MANNER OF DEATH		MEDICAL ATTENDANCE	
Natural		Yes	
CERTIFICATE NO.		FILE NO.	
12345		67890	

RECEIVED  
JUL 1 1957  
BUREAU V. 2

6010

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>BALT. CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6 mos 19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. STREET ADDRESS <b>3405 PINKNEY ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Virginia</b> Last <b>GLADMON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-75</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theopholous GLADMON</b>		14. MOTHER'S MAIDEN NAME <b>Mary ANDERSON Fleener</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary thrombosis and infarction</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOV 30</b> , 19 <b>56</b> , to <b>JUN 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>JUN 19</b> , 19 <b>57</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-19-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 22, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Teufel</b>		ADDRESS <b>5311 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '57</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 24 1957

RECEIVED





JUN 25 1957

RECEIVED

6012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr8mth26dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LYLE</b> Middle <b>EDWARD</b> Last <b>GOULD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1882</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Gilbert Gould</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Root</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>450.0</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 17</b> , 19 <b>57</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>57</b> , and that death occurred at <b>1:15p.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-10-57</b> ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6.13.57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anatoly Board</b> <b>29 S. Greene St.</b>				24a. REC'D BY REGISTRAR DATE <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Calvin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JUN 18 1957

RECEIVED  
JUN 18 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 38									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7925 York Rd.</b>					d. STREET ADDRESS <b>7925 York Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Avis</b> Middle <b>Quinn</b> Last <b>Griffin</b>					4. DATE OF DEATH Month <b>June 11,</b> Day <b>1957</b> Year <b>19</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1881</b>		9. AGE (In years rthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James T. Quinn</b>					14. MOTHER'S MAIDEN NAME <b>Alice Mary DeLargey</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James T. Griffin</b> Address <b>8428 Oakleigh Road Balto. 14, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>William V. Kovitt, Jr.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>William V. Kovitt, Jr., M.D.</b>					DATE SIGNED <b>6/12/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns, Sons</b>				ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>June 13, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

06007

Reg. Dist. No. 38



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. S.

JUN 17 1957

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES M. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD.		JUN 25 1957		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
Carpenter		Heart Disease		Natural		Coronary Artery Disease		3 weeks		None		Hospital		None	
EDUCATION		SCHOOLING		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED	
High School		8 years		Catholic		Married		Yes		Yes		Yes		Yes	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
John M. Smith		Mary E. Smith		Carpenter		Homemaker		Maryland		Maryland		Jan 15 1850		Jan 15 1850	
FAMILY HISTORY		PREVIOUS DEATHS		PREVIOUS ILLNESSES		PREVIOUS SURGERIES		PREVIOUS TRAUMAS		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF NURSE		SIGNATURE OF CHAPLAIN		SIGNATURE OF MINISTER	

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6015

## CERTIFICATE OF DEATH

06009

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>84 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2340 W. Lexington Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>S.</b> Last <b>HAIRSTON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1898</b>	
9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR Months <b>59</b>		IF UNDER 24 HRS. Days <b>59</b> Hours <b>59</b> Min. <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Ridgeway, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Hairston</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>230-12-6422</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF STOMACH WITH METASTASES TO</b> <b>ABDOMINAL WALL AND LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>UNKNOWN</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 19, 1957</b> , to <b>June 11, 1957</b> , and that death occurred at <b>10:50 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>6/11/57</b>	
PHYSICIAN'S NAME (Type) <b>CH IEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary 802-04 Madison Ave.</b>				ADDRESS <b>Baltimore 1, Md.</b>		24a. REC'D BY REGISTRAR <b>Dawson J. Farley</b>	
24b. REGISTRAR'S SIGNATURE							

RECEIVED

JUN 17 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH	
1. Name of deceased: <u>John W. Jackson</u>	
2. Date of death: <u>June 1, 1957</u>	
3. Place of death: <u>John W. Jackson Hospital</u>	
4. Age: <u>67</u> years	
5. Sex: <u>Male</u>	
6. Race: <u>White</u>	
7. Marital status: <u>Married</u>	
8. Occupation: <u>Engineer</u>	
9. Cause of death: <u>Myocardial infarction</u>	
10. Date of burial: <u>June 3, 1957</u>	
11. Name of funeral home: <u>John W. Jackson Funeral Home</u>	
12. Signature of physician: <u>[Signature]</u>	
13. Signature of registrar: <u>[Signature]</u>	

6016

## CERTIFICATE OF DEATH

06010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE CITY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 3Y01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MT. WILSON STATE HOSP</u>				d. STREET ADDRESS <u>46 MARKET PLACE</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>PHILIP</u> Last <u>HAWE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-11-02</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBERSHOP</u>		11. BIRTHPLACE (State or foreign country) <u>BURKIN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. HAWK</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL SARMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>197-10-4475</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1-22</u> , 19 <u>57</u> , to <u>6-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-4</u> , 19 <u>57</u> , and that death occurred at <u>1:50</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>William Newcomer, M. D., Superintendent</u> <u>Mt. Wilson, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Embalmment</u>		<u>June 7/57</u>		<u>St. Elizabeth's Cemetery</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				24a. REC'D BY REGISTRAR DATE <u>6/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

JUN 13 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06011 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO 14</u>		c. LENGTH OF STAY IN 1b <u>15-16-yr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3022 Texas Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara</u> First <u>mae</u> Middle <u>Harris</u> Last		4. DATE OF DEATH <u>June 9</u> Month <u>9</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 - 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Bradley ne Bradley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>HERBERT DULL 1228 DUREST 30</u>	
17. INFORMANT <u>HERBERT DULL 1228 DUREST 30</u>		Address <u>1228 DUREST 30</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>undet</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>undet</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>June 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Brown</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and form fields, including sections for cause of death, manner of death, and medical history.]*

**RECEIVED**  
JUN 11 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

6018 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06012									
Medical Examiner									
CERTIFICATE OF DEATH									
Reg. Dist. No. 43									
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6,					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6, X0				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1206 Chesaco Avenue					d. STREET ADDRESS 1206 Chesaco Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First F. Middle Irene Last Harrison			4. DATE OF DEATH Month June Day 18 Year 19 57						
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 4, 1878		9. AGE (In years last birthday) yrs. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Tull				14. MOTHER'S MAIDEN NAME Laura Barnett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Laura Lewis, 1206 Chesaco Avenue, Baltimore 6					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Left Hip (fall down stairs) 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stairs at home 20c. TIME OF INJURY Hour 8 p.m. Month 2 Day 2 Year 19 57 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Baltimore 6 Md 21. I certify that I attended the deceased from June 19 38, to June 18 19 57, that I last saw the deceased alive on 6-15 19 57, and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3025 Belair Road ACTUAL SIGNATURE William E. Henry M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 6-20-57 22c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Cook, Inc., 1217 St. Paul Street 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mrs. D. L. DeLozier JUN 20 1957									

# CERTIFICATE OF DEATH

BUREAU V. S.

JUN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours, after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6019

CERTIFICATE OF DEATH

06013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>52 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3240 Westmont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>R.</b> Last <b>HAYNES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 57</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 27, 1895</b>		9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>62</b>		IF UNDER 24 HRS. Days <b>62</b> Hours <b>62</b> Min. <b>62</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Trucking</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William S. Haynes</b>						14. MOTHER'S MAIDEN NAME <b>Annie M. Bantown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>216-09-4250</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VESICO-INTESTINAL FISTULA</b> <b>181X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF URINARY BLADDER</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b> <b>9 MONTHS</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 26, 19 57</b> , to <b>June 17, 19 57</b> and that death occurred at <b>1:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>CHEN WEI LAN, M.D. V.A.H., FORT HOWARD, MARYLAND 6/17/57</b>															
ACTUAL SIGNATURE <b>CHEN WEI LAN, M.D.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b> ADDRESS						24a. REC'D BY REGISTRAR <b>6/1/57</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisher</b>							



BUREAU V. S.

JUN 24 1957

RECEIVED



6020  
CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1730 Wycliffe Road</u>		d. STREET ADDRESS <u>1730 Wycliffe Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Raymond</u> Middle <u>B.</u> Last <u>Hazelip</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12th</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.S. &amp; D. Super-Used Cars</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin C. Hazelip</u>		14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Ida Mae Hazelip, 1730 Wycliffe Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/7</u> 19 <u>57</u> to <u>6/12/57</u> 19 <u>57</u> , that I lost saw the deceased alive on <u>6/12/57</u> 19 <u>57</u> , and that death occurred at <u>1:32 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1016 East Len</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Mitchell F. Runkowski</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Mitchell F. Runkowski</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	24a. REC'D BY REGISTRY <u>13 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Dr. U. M. Barry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06015

6021

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Spring Grove State Hosp.</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>—</u> Last <u>Heaps</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-73</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. Phelps</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Wesley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wiley Heaps (deceased)</u> Address <u>NEW YORK, NY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of heart arteries</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>many years</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>300.3 Schizophrenic reaction paranooid type chronic</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>23</u> , to <u>June 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William N. Karn, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp</u> DATE SIGNED <u>6-2-57</u>			
PHYSICIAN'S NAME (Type) <u>William N. Karn, Jr. MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>AYRES CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>WHITE HALL, HARFORD CO., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Penelope W. Chubb</u> ADDRESS <u>Stevenson Pa.</u>				24a. REC'D BY REGISTRAR <u>JOHN G</u> DATE <u>57</u>		24b. REGISTRAR'S SIGNATURE <u>W. C. ...</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 6 1957

RECEIVED

15-27 Hines Chapter

15-27 Hines Chapter

6022

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1513 Ellamont Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>NMI</b> Last <b>HENDERSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/26/15</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Company</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>EDD HENDERSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY J. JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>252-18-9685</b>		17. INFORMANT <b>Clin.Rec.Vets.Admin.Hospital, Ft.Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AZOTEMIA</b> <b>592X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GLOMERULONEPHRITIS CHRONIC</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 weeks</b> <b>3 1/2 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardio vascular disease seconary to #1</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>443X</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9</b> , 19 <b>57</b> , to <b>M June 29</b> , 19 <b>57</b> , that death occurred on <b>June 29</b> , 19 <b>57</b> , at <b>2:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>S. Q. ARCE</b> M.D. <b>Veterans Administration Hospital</b> PHYSICIAN'S NAME (Type) <b>S. Q. ARCE, M. D.</b> <b>Fort Howard, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				ADDRESS <b>802-04 Madison Ave, Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>2</b> 1957	
24b. REGISTRAR'S SIGNATURE <b>L. F. L. F.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V.

2 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

0716144

6923

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>8 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>935 West Saratoga Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>W.</b> Last <b>HENSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1957</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 24, 1898</b>		9. AGE (In years and birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>27</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public building</b>				11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Tobias Henson</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Goodrich</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>212-18-0976</b>				17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, PRIMARY SITE UNDETERMINED</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month <b>June</b> Day <b>19</b> Year <b>1957</b> Hour <b>10:50 P.</b> m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Fort Howard</b> (County) <b>Baltimore</b> (State) <b>Md.</b>					
21. I certify that I attended the deceased from <b>June 19, 1957</b> to <b>June 27, 1957</b> and that death occurred at <b>10:50 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/28/57</b>													
ACTUAL SIGNATURE <b>Irving Freeman</b>				M.D. <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>									
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b> (State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese</b> ADDRESS <b>108 W. Washington St., Annapolis, Md.</b>						24a. RECEIVED BY REGISTRAR <b>3023</b> DATE <b>1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Parley</b>					

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX Male		AGE 8 years	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "1949"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Maryland"]	
OCCUPATION [Faint text, possibly "Student"]		CAUSE OF DEATH [Faint text, possibly "Sudden cardiac arrest"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "July 1, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

BUREAU V. F.

JUL 8 1957

RECEIVED

## 6024 CERTIFICATE OF DEATH

06017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>2 months, 28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>Balto 23, Md. 3V01-4</u>			
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Marie</u> Last <u>Higdon</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1896</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>	
13. FATHER'S NAME <u>Leopold</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>-</u>				17. INFORMANT <u>Charles Higdon 709 Scarlett Drive Towson 4, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X Congestive heart failure</u> DUE TO (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 8, 1957</u> , to <u>June 5<sup>th</sup>, 1957</u> , that I last saw the deceased alive on <u>June 5<sup>th</sup>, 1957</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove Hosp - Balto 23</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES WARD, MD</u>				DATE SIGNED <u>6/5/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Witzke</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 7 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and signature. The form is oriented horizontally but contains vertical text elements.

NAME: [Illegible]

DATE: [Illegible]

CAUSE OF DEATH: [Illegible]

SIGNATURE: [Illegible]

BUREAU V. S.

JUN 10 1957

RECEIVED

## 6025 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6mths 27dys</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belair, Maryland 12322</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			
d. STREET ADDRESS <b>408 Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Susan</b> Last <b>Hines</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1874</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ralph Woodward</b>				14. MOTHER'S MAIDEN NAME <b>Manda Lancey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung abscess and Pneumonia</b> <b>521X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1 Arterioscl. Cardiovasc. Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 6, 1957</b> to <b>June 17, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>3:40p</b> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-17-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				LOCATION (City, town, or county) (State) <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fountain Green, Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>				ADDRESS <b>Broadway &amp; Williams Street Bel Air, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 20 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

THE BUREAU OF

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JUN 18 1951		BALTIMORE, MD.	
MOTHER'S NAME		FATHER'S NAME		MARRIAGE		EDUCATION		OCCUPATION		RELIGION	
MARY H. HARRIS		JOHN H. HARRIS		MAY 15 1910		HIGH SCHOOL		LABORER		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
NONE		HEART DISEASE		NATURAL		JUN 18 1951		JAMES H. HARRIS		JOHN H. HARRIS	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
JUN 20 1951		BALTIMORE, MD.		JAMES H. HARRIS		JOHN H. HARRIS		METHODIST CHURCH		BALTIMORE CEMETERY	

BUREAU V. 2

JUN 20 1951

RECEIVED



6026

## CERTIFICATE OF DEATH

06019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Della</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Della</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 Della Ave</u>		d. STREET ADDRESS <u>102 Della Ave</u>	
3. NAME OF DECEASED (Type or print) <u>EUGENE EDGAR</u> First Middle Last		4. DATE OF DEATH <u>6/29/57</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U. S. a.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipy mill</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. a.</u>	
13. FATHER'S NAME <u>John Hobson</u>		14. MOTHER'S MAIDEN NAME <u>Reese</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>162X</u>	
17. INFORMANT <u>Margaret Buffington</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma left lung</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>57</u> , to <u>6-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-28</u> , 19 <u>57</u> , and that death occurred at <u>9:50</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Buegter</u> M.D.		ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>	
DATE SIGNED <u>6-30-57</u>		PHYSICIAN'S NAME (Type) <u>Ellicott City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Nabb + Son</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 3 '57</u>	
ADDRESS <u>28</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-57

<p>1. Name of deceased: <i>William Thomas</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>10/10/1908</i></p>		<p>4. Place of birth: <i>St. Louis, Mo.</i></p>	
<p>5. Date of death: <i>10/24/57</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Myocardial infarction</i></p>		<p>8. Immediate cause: <i>Coronary artery disease</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Usual place of abode: <i>Home</i></p>	
<p>11. Name of attending physician: <i>Dr. J. H. Smith</i></p>		<p>12. Name of medical examiner: <i>Dr. J. H. Smith</i></p>	
<p>13. Name of funeral home: <i>None</i></p>		<p>14. Name of cemetery: <i>None</i></p>	
<p>15. Name of informant: <i>None</i></p>		<p>16. Name of informant: <i>None</i></p>	
<p>17. Name of informant: <i>None</i></p>		<p>18. Name of informant: <i>None</i></p>	
<p>19. Name of informant: <i>None</i></p>		<p>20. Name of informant: <i>None</i></p>	
<p>21. Name of informant: <i>None</i></p>		<p>22. Name of informant: <i>None</i></p>	
<p>23. Name of informant: <i>None</i></p>		<p>24. Name of informant: <i>None</i></p>	
<p>25. Name of informant: <i>None</i></p>		<p>26. Name of informant: <i>None</i></p>	
<p>27. Name of informant: <i>None</i></p>		<p>28. Name of informant: <i>None</i></p>	
<p>29. Name of informant: <i>None</i></p>		<p>30. Name of informant: <i>None</i></p>	
<p>31. Name of informant: <i>None</i></p>		<p>32. Name of informant: <i>None</i></p>	
<p>33. Name of informant: <i>None</i></p>		<p>34. Name of informant: <i>None</i></p>	
<p>35. Name of informant: <i>None</i></p>		<p>36. Name of informant: <i>None</i></p>	
<p>37. Name of informant: <i>None</i></p>		<p>38. Name of informant: <i>None</i></p>	
<p>39. Name of informant: <i>None</i></p>		<p>40. Name of informant: <i>None</i></p>	
<p>41. Name of informant: <i>None</i></p>		<p>42. Name of informant: <i>None</i></p>	
<p>43. Name of informant: <i>None</i></p>		<p>44. Name of informant: <i>None</i></p>	
<p>45. Name of informant: <i>None</i></p>		<p>46. Name of informant: <i>None</i></p>	
<p>47. Name of informant: <i>None</i></p>		<p>48. Name of informant: <i>None</i></p>	
<p>49. Name of informant: <i>None</i></p>		<p>50. Name of informant: <i>None</i></p>	
<p>51. Name of informant: <i>None</i></p>		<p>52. Name of informant: <i>None</i></p>	
<p>53. Name of informant: <i>None</i></p>		<p>54. Name of informant: <i>None</i></p>	
<p>55. Name of informant: <i>None</i></p>		<p>56. Name of informant: <i>None</i></p>	
<p>57. Name of informant: <i>None</i></p>		<p>58. Name of informant: <i>None</i></p>	
<p>59. Name of informant: <i>None</i></p>		<p>60. Name of informant: <i>None</i></p>	
<p>61. Name of informant: <i>None</i></p>		<p>62. Name of informant: <i>None</i></p>	
<p>63. Name of informant: <i>None</i></p>		<p>64. Name of informant: <i>None</i></p>	
<p>65. Name of informant: <i>None</i></p>		<p>66. Name of informant: <i>None</i></p>	
<p>67. Name of informant: <i>None</i></p>		<p>68. Name of informant: <i>None</i></p>	
<p>69. Name of informant: <i>None</i></p>		<p>70. Name of informant: <i>None</i></p>	
<p>71. Name of informant: <i>None</i></p>		<p>72. Name of informant: <i>None</i></p>	
<p>73. Name of informant: <i>None</i></p>		<p>74. Name of informant: <i>None</i></p>	
<p>75. Name of informant: <i>None</i></p>		<p>76. Name of informant: <i>None</i></p>	
<p>77. Name of informant: <i>None</i></p>		<p>78. Name of informant: <i>None</i></p>	
<p>79. Name of informant: <i>None</i></p>		<p>80. Name of informant: <i>None</i></p>	
<p>81. Name of informant: <i>None</i></p>		<p>82. Name of informant: <i>None</i></p>	
<p>83. Name of informant: <i>None</i></p>		<p>84. Name of informant: <i>None</i></p>	
<p>85. Name of informant: <i>None</i></p>		<p>86. Name of informant: <i>None</i></p>	
<p>87. Name of informant: <i>None</i></p>		<p>88. Name of informant: <i>None</i></p>	
<p>89. Name of informant: <i>None</i></p>		<p>90. Name of informant: <i>None</i></p>	
<p>91. Name of informant: <i>None</i></p>		<p>92. Name of informant: <i>None</i></p>	
<p>93. Name of informant: <i>None</i></p>		<p>94. Name of informant: <i>None</i></p>	
<p>95. Name of informant: <i>None</i></p>		<p>96. Name of informant: <i>None</i></p>	
<p>97. Name of informant: <i>None</i></p>		<p>98. Name of informant: <i>None</i></p>	
<p>99. Name of informant: <i>None</i></p>		<p>100. Name of informant: <i>None</i></p>	

BUREAU V. 4

3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06020

6027

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 3401-4</i> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7826 Shephard Avenue</i>		d. STREET ADDRESS <i>1320 E. Belvedere Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Joseph H. Hoeck</i>		4. DATE OF DEATH <i>June 6th 19 57</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1884</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Commercial Artist</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John J. Hoeck</i>		14. MOTHER'S MAIDEN NAME <i>Mary F. Engel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>1</i>		16. SOCIAL SECURITY NO. <i>214-14-7033</i>	
17. INFORMANT <i>Mrs. Katherine M. Hoeck</i>		Address <i>1320 E. Belvedere</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Congestive Failure</i> <i>023X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ischemic Cardiovascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i> <i>Atherosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>55</i> , to <i>June</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 5</i> , 19 <i>57</i> , and that death occurred at <i>3:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. F. Palmisano</i>		DATE SIGNED <i>6/6/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Joseph F. Palmisano</i>		ADDRESS (Street, city or town, state) <i>6014 Loch Raven Blvd. Baltimore 12 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/10/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>J. D. M. Bacon</i>	
ADDRESS <i>5305 Harford Road #14</i>		DATE <i>JUN 10 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 01 NOV.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6028

CERTIFICATE OF DEATH

060217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 BALTIMORE (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>8545 PULASKI HIGHWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM DOSS HOLDREN</b>				4. DATE OF DEATH Month Day Year <b>6 8 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-10-1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE HELPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RUBBER</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE WILLIAM HOLDREN</b>				14. MOTHER'S MAIDEN NAME <b>MAE ABBOTT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>231-16-2547</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF EPIGLOTTIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>22X PULMONARY TUBERCULOSIS.</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-9-</b> , 19 <b>57</b> , to <b>6-7-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-7-</b> , 19 <b>57</b> , and that death occurred at <b>4 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>		<b>6.8.57</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>6/11/57</b>		<b>VERRYS CHAP. CHURCH</b>		<b>CHAMLISSBURG, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley</b>				ADDRESS <b>Dundalk Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/11/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

JUN 11 1957

RECEIVED



6029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>504 Academy Road</b>				d. STREET ADDRESS <b>504 Academy Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>W.</b> Middle <b>Howard</b> Last <b>Horton</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1887</b>		9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk, City Of Baltimore</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Horton</b>				14. MOTHER'S MAIDEN NAME <b>Emma</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>217-01-3710A</b>		17. INFORMANT Address <b>Mrs Katherine Horton, 504 Academy Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>thrombosis Cerebral</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/1</b> , 19 <b>57</b> to <b>6/27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/27</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C J Mendel</b>				ADDRESS (Street, city or town, state) <b>651 N Bentall Ave Baltimore Md</b>		DATE SIGNED <b>6/28/57</b>	
PHYSICIAN'S NAME (Type) <b>C J Mendel MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jul. 1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery, Balto. Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>				ADDRESS <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>JUL 1 '57</b> 24b. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1887		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH JUL 1 1957		PLACE OF DEATH BALTIMORE, MARYLAND		HOSPITAL OR CLINIC BALTIMORE HOSPITAL	
NAME OF PHYSICIAN DR. J. H. HARRIS		NAME OF FUNERAL HOME HARRIS FUNERAL HOME		NAME OF BURIAL PLACE BALTIMORE CEMETERY	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF FUNERAL HOME HARRIS FUNERAL HOME		SIGNATURE OF BURIAL PLACE BALTIMORE CEMETERY	
DATE OF SIGNATURE JUL 1 1957		DATE OF SIGNATURE JUL 1 1957		DATE OF SIGNATURE JUL 1 1957	

BUREAU V. S.

JUL 1 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6030

## CERTIFICATE OF DEATH

06023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2yr7mth14dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Maryland 16142</u>			
d. STREET ADDRESS <u>7403 Dartmouth Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Hottel</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newspaperman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Hottel</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>579-01-7848</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioscler. Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis gen. severe</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 22</u> , 19 <u>57</u> , to <u>June 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 9</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Stella Wachler</u> M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) <u>STELLA WACHLER</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6931

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06024

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2mths4dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3x01-4</u> ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>1533 Covington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>rigger</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William Edward Howard, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Birdie Betson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status convulsivus</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral hemorrhage</u> (c) <u>Hypertensive cardiovascular disease</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>581.1</u> <u>Laennec's cirrhosis of liver</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo M Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>He [unclear] [unclear] [unclear]</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 19 57</u>		24b. REGISTRAR'S SIGNATURE <u>[unclear]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

JUN 19 1957

BUREAU V. B.



6032

## CERTIFICATE OF DEATH

06925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2yr10mth16dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>Schieve</u> Last <u>Hubschmann</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 11, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Schieve</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Gregg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>56</u> , to <u>June 10</u> , 19 <u>57</u> at I last saw the deceased alive on <u>June 10</u> , 19 <u>57</u> , and that death occurred at <u>2:00a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 6-10-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>CATONSVILLE 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Henry Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				24a. REC'D BY REGISTRAR <u>Stollins</u>		24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5940

CERTIFICATE OF DEATH

06026 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 COLGATE AVE.</u>		d. STREET ADDRESS <u>1221 COLGATE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>TILLEY</u> Last <u>HYDE</u>		4. DATE OF DEATH Month <u>6-28-</u> Day <u>1957</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 14, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH TILLEY</u>		14. MOTHER'S MAIDEN NAME <u>SARAH COLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>BENJ. HYDE</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>592X</u> <u>chronic nephritis - arteriosclerotic</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1957</u> Hour a. p. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 15, 1956</u> , to <u>June 28, 1957</u> , that I last saw the deceased alive on <u>June 28, 1957</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6/29/57</u>			
ACTUAL SIGNATURE <u>J. Howard Burns</u> M.D.			
PHYSICIAN'S NAME (Type) <u>J. HOWARD BURNS, M.D.</u>		<u>59 DUNDALK AVE. DUNDALK 22, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

# CERTIFICATE OF DEATH

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 3

JUL 2 1957

RECEIVED

DATE OF DEATH		PLACE OF DEATH		CITY AND COUNTY	
TIME OF DEATH		NATURAL CAUSE		MANNER OF DEATH	
AGE		SEX		RACE	
BIRTH DATE		BIRTH PLACE		EDUCATION	
OCCUPATION		MARRIAGE		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		LABORATORY TESTS		POSTMORTEM EXAMINATION	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	

6033

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAY SHORE - Sp Pt - 19</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b> 3V 01-4	
d. STREET ADDRESS <b>2112 E. PRATT ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BURL</b> Middle <b>M.</b> Last <b>HYER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1929</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Washer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Esskay, Inc.</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HARRY W. Hyer</b>	
14. MOTHER'S MAIDEN NAME <b>Julia E. Perrine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> Korea	
16. SOCIAL SECURITY NO. <b>271-32-00</b>		17. INFORMANT <b>Arthur B. Hyer</b> Address <b>BALTO., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stepped in hole while swimming off Bay Shore</b>		20c. TIME OF INJURY Month, Day, Year <b>Hour</b> <b>6-17</b> <b>1957</b> <b>p. m.</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bay Ne Bay Shore Sp. Pt - 19</b>	
20f. (City or town) <b>BALTO</b>		20g. (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/17/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>6/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Morrison Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Jitter, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Ellrich</b>		24. REC'D BY REGISTRAR <b>24 1957</b>	
25. REGISTRAR'S SIGNATURE <b>Lawson L. Huber</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.



1  
 BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED



6034

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b> <b>3401-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcast Nursing Home</b> <b>812 Register Avenue</b>		d. STREET ADDRESS <b>1521 Argonne Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Freda</b> <b>C.</b> <b>Irwin</b>		4. DATE OF DEATH <b>June</b> <b>8</b> <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1886</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward Specht</b>		14. MOTHER'S MAIDEN NAME <b>Sophia (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John S. Irwin, 1521 Argonne Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422 Anteroseclerotic Cardio-Vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr. ?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar.</b> <b>1957</b> to <b>June</b> <b>1957</b> , that I last saw the deceased alive on <b>June 7</b> <b>1957</b> , and that death occurred at <b>7:15 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Loy M. Zimmerman</b> M.D.		ADDRESS (Street, city or town, state) <b>3202 Hartford Rd.</b>	
DATE SIGNED <b>June 10 1957</b>			
PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman</b>		<b>Baltimore - 18, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-11-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>DATE JUN 12 1957</b>	
24a. REC'D BY REGISTRAR <b>Mark Gray</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. S.

JUN 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06029

6035

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. LENGTH OF STAY IN 1b <b>32 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2725 Hudson Street</b>			
3. NAME OF DECEASED (Type or print) <b>JANUCHOWSKI First</b> <b>JOHN</b>				MIDDLE <b>F. De Martin</b> Last <b>JANUHOSKI</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 57</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/24/ 85</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Pete Januhoski</b>				14. MOTHER'S MAIDEN NAME <b>Januchowski</b> <b>Thelma (Maiden Name Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>SAW</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Clin Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GASTRIC CARCINOMA</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from <b>May 15</b> , 19 <b>57</b> , to <b>June 16</b> , 19 <b>57</b> , and that death occurred at <b>7:55P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>6/16/57</b> ACTUAL SIGNATURE <b>Garfield D. Kington</b> M.D. PHYSICIAN'S NAME (Type) <b>GARFIELD D. KINGTON, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JUNE 19, 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Weber Funeral Home, 401 S. Chester St.</b> <b>Baltimore, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>L. L. L. L.</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED John M. Fisher		SEX Male		RACE White		DATE OF BIRTH 1895		PLACE OF BIRTH Boston, Mass.	
RESIDENCE 123 Main Street, Boston, Mass.		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		DATE OF DEATH 1957		PLACE OF DEATH Boston, Mass.	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. B.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6036

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #17 3501-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>918 N. Gilmore Street</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/23</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labrwr</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>Theresa M. Neville</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Annie M. Johnson</b>		Address <b>913 Cherry Hill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> DUE TO <b>914.3</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Electrocuted while at work.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6/14 1957</b> Hour <b>11:00</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		DATE SIGNED <b>6/14/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield Church</b>		22d. LOCATION (City, town, or county) <b>Littleton - N. C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Ayer</b>		24a. REC'D BY REGISTRAR <b>17 1957</b> DATE	
ADDRESS <b>678 N. Gilmore</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisher</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. Jones		Male		45	
Residence		Occupation		Cause of Death	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease	
Date of Death		Place of Death		Time of Death	
June 15, 1957		Home		10:30 AM	

*Handwritten notes:*  
 11/13/53  
 U.C.  
 John J. Jones  
 1234 Main St., Baltimore, Md.  
 Cause of Death: Heart Disease

BUREAU V. S.

JUN 17 1957

RECEIVED

*Handwritten notes at bottom:*  
 John J. Jones  
 1234 Main St., Baltimore, Md.  
 Cause of Death: Heart Disease



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0603133

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>43 Bond Ave.</b>		d. STREET ADDRESS <b>43 Bond Ave.</b>							
3. NAME OF DECEASED (Type or print) <b>SARAH ELIZABETH JONES</b>		First Middle Last		4. DATE OF DEATH <b>June 6, 1957</b>		Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1887</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>A.A.Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Fletcher</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daisy Lee</b>		Address <b>43 Bond Ave Reisterstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>447X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 3, 1957</b> to <b>June 6, 1957</b> that I last saw the deceased alive on <b>June 6, 1957</b> and that death occurred at <b>3:50 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Reisterstown, Maryland</b>		DATE SIGNED <b>June 6, 1957</b>					
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Lansdowne Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ms. Kate R. Williams</b>		ADDRESS <b>322 N. Schroeder St</b>		24a. REC'D BY REGISTRAR <b>DATE 6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Eline</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

**RECEIVED**  
JUN 11 1957  
BUREAU V. 2

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE, ALABAMA		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1948		MEMPHIS		TENNESSEE		UNITED STATES		JUN 6 1968		MEMPHIS		TENNESSEE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFIED BY	
ATTORNEY		1967		MEMPHIS		TENNESSEE		UNITED STATES		HEART DISEASE		NATURAL		JAMES EARL RAY	
SIGNATURE OF DECEASED		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF PHYSICIAN		DATE		PLACE	
JAMES EARL RAY		1968		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY		1968		MEMPHIS	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF REGISTRAR		DATE		PLACE	
JAMES EARL RAY		1968		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY		1968		MEMPHIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06032

6038

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths10dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3341 Windsor Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>J.</b> Last <b>Knell</b>		4. DATE OF DEATH Month <b>June 14,</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1879</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew Knell, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Roume</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4, 1957</b> , to <b>June 14, 1957</b> , that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>1:15aM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>6-14-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Baltimore</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 17 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Outman</b>			

CERTIFICATE OF DEATH

RECEIVED  
JUN 18 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6039 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06033  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - Hamilton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>4102 Hamilton Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>CLIFTON</b> Last <b>KNOPP</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/8/1938</b>	
9. AGE (In years last birthday) <b>19</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman Western Electric Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Harry C. Knopp</b>				14. MOTHER'S MAIDEN NAME <b>Catherine M. Bartenfelter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-36-4552</b>			
17. INFORMANT <b>Catherine M. Knopp</b>				Address <b>4102 Hamilton Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned</b>			
20c. TIME OF INJURY Hour <b>3</b> p. m. Month, Day, Year <b>6/22 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beaver Dam</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6/27/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence F. Hoffman</b>				ADDRESS <b>3218 Anderson St</b>			
24a. REC'D BY REGISTRAR <b>JUN 28 '57</b>				24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

City of Boston - Hamilton

1102 Hamilton Avenue

June 19

REPORT

DEATH

HANLEY

Male

White

W/1950

Boston

Hamilton

Hamilton

1102 Hamilton Avenue

Hamilton

Found drowned

1102 Hamilton Avenue

Hamilton

BUREAU V. 3

JUL 1 1957

RECEIVED



6040

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>714 Maryland Ave</u>				d. STREET ADDRESS <u>714 Maryland Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Fannie</u> First Middle Last <u>Kotroco</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Novak</u>				14. MOTHER'S MAIDEN NAME <u>Julia Borgart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Louis J. Kotroco</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, most acute</u> <u>443X</u> DUE TO <u>Heart failure, acute, backward</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V.D &amp; heart failure, chronic</u> (c) <u>Several years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 minutes</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>September 6, 1956</u> , to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>0:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene C. Baumann</u> M.D.				ADDRESS (Street, city or town, state) <u>413 Eastern Ave Essex, Md</u>			
DATE SIGNED <u>6-12-57</u>							
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brudzinski</u> ADDRESS <u>1407 Eastern Ave</u>				24. REGISTERED BY REGISTRAR <u>June 13 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Edith H. Huley</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 13 1957

RECEIVED

6041

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3101.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2 E. Biddle Street</b>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>(NMI)</b> Last <b>LAMONT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/96</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Drydock</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Alexander Lamont</b>				14. MOTHER'S MAIDEN NAME <b>Mary Glen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>107-05-3191</b>		17. INFORMANT <b>Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LARGE BOWEL WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>TO PERINEUM</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>January 4</b> , 19 <b>57</b> , to <b>June 2</b> , 19 <b>57</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. A. Baranowski</i>				ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b>			
PHYSICIAN'S NAME (Type) <b>J. A. BARANOWSKI, M. D.</b>				DATE SIGNED <b>6/2/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home 130 E. Fort Ave.</b>				24a. REC'D BY REG. DIST. <b>1957</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Harber</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Age

Baltimore

115 days

Post Mortem

2 E. Biddle Street

Veterans Administration Hospital

June 2 1957

LABORATORY

(MAY)

DAVID

115 days

61

2/25/56

115 days

White

115 days

115 days

115 days

115 days

Harry Glen

Alexander Lambert

115 days

115 days

115 days

115 days

115 days

TO BEGINNING

BUREAU V. B.

JUN 4 1957

RECEIVED

115 days

115 days

115 days

115 days

115 days

115 days

115 days

6042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 A Merrill Road</b>				d. STREET ADDRESS <b>16 A Merrill Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CORA RYAN LAWRENCE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles Ryan</b>				14. MOTHER'S MAIDEN NAME <b>SARAH <del>Babcock</del> Matheny</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Miss Ruth Lawrence 16 A Merrill Rd. Catonsville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cordis-Vascular Disease</b> DUE TO (c) <b>3 days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 17, 1957</b> to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Michael L. De Vincentis</b> M.D.				ADDRESS (Street, city or town, state) <b>11 E. Chase St. Baltimore 2, Md</b> DATE SIGNED <b>6/20/57</b>			
PHYSICIAN'S NAME (Type) <b>MICHAEL L. DE VINCENTIS, M.D.</b>				<b>11 E. CHASE ST. BALTIMORE 2, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/25/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Craig Missouri</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>				ADDRESS <b>Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

MEDICAL CERTIFICATION



# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

BUREAU V. 2

JUN 24 1957

RECEIVED



1  
7  
14  
1  
0  
1  
MEDICAL CERTIFICATION  
TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06037

6043

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove Syaye Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William August Lehnert, Sr.</b>		4. DATE OF DEATH <b>June 26, 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-1871</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ernest Lehnert</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Mullmeyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital records, Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19 57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 27, 19 56</b> , to <b>June 26, 19 57</b> , that I last saw the deceased alive on <b>June 26, 19 57</b> , and that death occurred at <b>6:35 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louie Frances Woodward</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOS.</b> DATE SIGNED <b>6-26-57</b>	
PHYSICIAN'S NAME (Type) <b>Louie Frances Woodward, M. D.</b>		Spring Grove State Hospital, Catonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery, Baltimore, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Baltimore</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 1 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Redmond</b>			

RECEIVED

JUL 1 1957

BUREAU V. S.

HARTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS	
CERTIFICATE OF DEATH	
NAME OF DECEASED: [illegible]	
DATE OF DEATH: [illegible]	
PLACE OF DEATH: [illegible]	
CAUSE OF DEATH: [illegible]	
MANNER OF DEATH: [illegible]	
AGE: [illegible]	
SEX: [illegible]	
RACE: [illegible]	
BIRTH DATE: [illegible]	
BIRTH PLACE: [illegible]	
MARRIAGE DATE: [illegible]	
MARRIAGE PLACE: [illegible]	
OCCUPATION: [illegible]	
EDUCATION: [illegible]	
RELIGION: [illegible]	
MILITARY SERVICE: [illegible]	
PREVIOUS ILLNESS: [illegible]	
TREATMENT: [illegible]	
HOSPITAL: [illegible]	
PHYSICIAN: [illegible]	
BURIAL PLACE: [illegible]	
DATE OF BURIAL: [illegible]	
SIGNATURE OF DECEASED: [illegible]	
SIGNATURE OF WITNESS: [illegible]	
SIGNATURE OF PHYSICIAN: [illegible]	
SIGNATURE OF CLERK: [illegible]	

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6044

## CERTIFICATE OF DEATH

06038 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville 8, Md. Rural</u>			
				d. STREET ADDRESS <u>12 Dreher Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Emily</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1889</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fruitland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Elijah Smullen</u>		14. MOTHER'S MAIDEN NAME <u>Lokey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Edward L. Mortimer</u>		Address <u>Pikesville, Md. 12 Dreher Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TOXEMIA</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>POST-OPERATIVE MID-THIGH AMPUTATION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POST-OPERATIVE MID-THIGH AMPUTATION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 5, 1957</u> to <u>JUNE 19, 1957</u> , that I last saw the deceased alive on <u>JUNE 19, 1957</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel P. Scalia</u>				ADDRESS (Street, city or town, state) <u>1331 REISTERSTOWN ROAD</u>			
PHYSICIAN'S NAME (Type) <u>Samuel P. Scalia</u>				DATE SIGNED <u>6/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Meth. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Brothy Newell</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JUN 24 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06039

6045

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson - rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x0</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>702 Regester Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>HOOD</b> Last <b>LIVINGSTON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec.</b>		11. BIRTHPLACE (State or foreign country) <b>R. I.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Richard Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Christine Hood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War I</b>		17. INFORMANT <b>Mrs. Bessie J. Livingston - 702 Regester Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Chronic De compensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> (c) <b>3 Months</b> <b>6 Months</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.3</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Oct 7, 1948</b> to <b>June 27, 1957</b> , that I last saw the deceased alive on <b>June 24, 1957</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ADDRESS (Street, city or town, state) <b>2501 46th Rd Baltimore, Md</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>				DATE SIGNED <b>6/27/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		22b. DATE THEREOF <b>6-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Powtucket Cern.</b>		22d. LOCATION (City, town, or county) (State) <b>Powtucket, R. I.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Luckner &amp; Sons - Balt. 17, Md</b>				24a. REC'D BY REGISTRAR <b>DATE 6/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Malcolm Guyon</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Name of informant: _____</p>		<p>16. Address of informant: _____</p>	
<p>17. Name of informant: _____</p>		<p>18. Address of informant: _____</p>	
<p>19. Name of informant: _____</p>		<p>20. Address of informant: _____</p>	
<p>21. Name of informant: _____</p>		<p>22. Address of informant: _____</p>	
<p>23. Name of informant: _____</p>		<p>24. Address of informant: _____</p>	
<p>25. Name of informant: _____</p>		<p>26. Address of informant: _____</p>	
<p>27. Name of informant: _____</p>		<p>28. Address of informant: _____</p>	
<p>29. Name of informant: _____</p>		<p>30. Address of informant: _____</p>	
<p>31. Name of informant: _____</p>		<p>32. Address of informant: _____</p>	
<p>33. Name of informant: _____</p>		<p>34. Address of informant: _____</p>	
<p>35. Name of informant: _____</p>		<p>36. Address of informant: _____</p>	
<p>37. Name of informant: _____</p>		<p>38. Address of informant: _____</p>	
<p>39. Name of informant: _____</p>		<p>40. Address of informant: _____</p>	
<p>41. Name of informant: _____</p>		<p>42. Address of informant: _____</p>	
<p>43. Name of informant: _____</p>		<p>44. Address of informant: _____</p>	
<p>45. Name of informant: _____</p>		<p>46. Address of informant: _____</p>	
<p>47. Name of informant: _____</p>		<p>48. Address of informant: _____</p>	
<p>49. Name of informant: _____</p>		<p>50. Address of informant: _____</p>	
<p>51. Name of informant: _____</p>		<p>52. Address of informant: _____</p>	
<p>53. Name of informant: _____</p>		<p>54. Address of informant: _____</p>	
<p>55. Name of informant: _____</p>		<p>56. Address of informant: _____</p>	
<p>57. Name of informant: _____</p>		<p>58. Address of informant: _____</p>	
<p>59. Name of informant: _____</p>		<p>60. Address of informant: _____</p>	
<p>61. Name of informant: _____</p>		<p>62. Address of informant: _____</p>	
<p>63. Name of informant: _____</p>		<p>64. Address of informant: _____</p>	
<p>65. Name of informant: _____</p>		<p>66. Address of informant: _____</p>	
<p>67. Name of informant: _____</p>		<p>68. Address of informant: _____</p>	
<p>69. Name of informant: _____</p>		<p>70. Address of informant: _____</p>	
<p>71. Name of informant: _____</p>		<p>72. Address of informant: _____</p>	
<p>73. Name of informant: _____</p>		<p>74. Address of informant: _____</p>	
<p>75. Name of informant: _____</p>		<p>76. Address of informant: _____</p>	
<p>77. Name of informant: _____</p>		<p>78. Address of informant: _____</p>	
<p>79. Name of informant: _____</p>		<p>80. Address of informant: _____</p>	
<p>81. Name of informant: _____</p>		<p>82. Address of informant: _____</p>	
<p>83. Name of informant: _____</p>		<p>84. Address of informant: _____</p>	
<p>85. Name of informant: _____</p>		<p>86. Address of informant: _____</p>	
<p>87. Name of informant: _____</p>		<p>88. Address of informant: _____</p>	
<p>89. Name of informant: _____</p>		<p>90. Address of informant: _____</p>	
<p>91. Name of informant: _____</p>		<p>92. Address of informant: _____</p>	
<p>93. Name of informant: _____</p>		<p>94. Address of informant: _____</p>	
<p>95. Name of informant: _____</p>		<p>96. Address of informant: _____</p>	
<p>97. Name of informant: _____</p>		<p>98. Address of informant: _____</p>	
<p>99. Name of informant: _____</p>		<p>100. Address of informant: _____</p>	

BUREAU V. S.

JUN 20 1957

RECEIVED



6046

06040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3mths28dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Just</b> Middle <b>Thomsen</b> Last <b>Lund</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1903</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>economist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Kristoffer Lund</b>				14. MOTHER'S MAIDEN NAME <b>Berthäena Skot</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized and cerebral arteriosclerosis</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 22</b> , 19 <b>57</b> to <b>June 17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 17</b> , 19 <b>57</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				DATE SIGNED <b>6-18-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				ADDRESS <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington D.C.</b>				ADDRESS <b>2901-14 St.</b>		24a. REGISTRY REGISTRAR DATE <b>JUN 20 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JUN 20 1957

RECEIVED

6047

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>6 yrs. 6 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1001 West Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Isabel</b> Middle <b>(Lunig)</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Lunig</b>		14. MOTHER'S MAIDEN NAME <b>Rosalie Hildebrand</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Convent Records, 1001 W. Joppa Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 7, 1950</b> to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 19, 1957</b> , and that death occurred at <b>7:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road</b> DATE SIGNED <b>JUN 20 1957</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 22, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Vernon Emerson</b>		24a. REG'D BY REGISTRAR <b>JUN 24 1957</b>	
ADDRESS <b>4611 Park Heights Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Michael Guy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
John Doe		Jan 1, 1900	
Sex		Race	
Male		White	
Marital Status		Cause of Death	
Married		Heart Disease	
Place of Death		Date of Death	
New York City		Jan 15, 1957	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

JUN 24 1957

RECEIVED

NEW YORK, N.Y. 10001

511 Park Heights Ave.

6948

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>13½ Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>	
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>W.</b> Last <b>MADARY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 31, 1909</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Madary</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>215-05-3861</b>	
17. INFORMANT Address <b>Glin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>POSTERIOR MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RIGHT CORONARY THROMBOSIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>12 HOURS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephrosclerosis 446X</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6, 3:15 PM '57</b> to <b>June 7, 4:45 AM '57</b> and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FT. HOWARD, MARYLAND 6/7/57</b>			
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FT. HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenhaven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James L. McCully, 237 Patapsco Ave., Balto., Md.</b>		24. REG'D BY REGISTRAR DATE <b>JUN 10 1957</b> 25. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - JUNE 10 1957

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF MINISTER [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF [Illegible]	

RECEIVED  
 JUN 10 1957  
 BUREAU V. S.



6049

## CERTIFICATE OF DEATH

06043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville.</b>		c. LENGTH OF STAY IN 1b <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1919 Rockwell Ave.</b>		d. STREET ADDRESS <b>1919 Rockwell Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>ANN</b> Last <b>McCORMICK</b>		4. DATE OF DEATH Month <b>June 17,</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George A. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Groh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Ella Mae Clemens - 1919 Rockwell Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS, CEREBRAL</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE (ELABILE HYPERTENSION)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>731X</b> (b) <b>10 YEARS</b> (c) <b>1443X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) PAGETS DISEASE; (2) OSTEOARTHRITIS, SEVERE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-1</b> , 19 <b>56</b> , to <b>6-17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-17</b> , 19 <b>57</b> , and that death occurred at <b>4:03 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b>		ADDRESS (Street, city or town, state) <b>401 RANDOM RD., BALTO., MD.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER M.D.</b>		DATE SIGNED <b>6-19-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Schaefer &amp; Son - Balto.</b>		24a. REC'D BY REGISTRAR <b>JUN 19 57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Form No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6050

## CERTIFICATE OF DEATH

0604437  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3V01-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MT WILSON ST HOSPITAL</b>				d. STREET ADDRESS <b>2405 E. PRESTON ST.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA WASHINGTON MC CULLOUGH</b>				4. DATE OF DEATH Month Day Year <b>6 2 1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2.22.1875</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY BURKHEAD</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE SWORMJEDT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MITRAL DISEASE, GENERALIZED ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>450.0</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. : 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7.5</b> , 19 <b>55</b> , to <b>6.2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6.2</b> , 19 <b>57</b> , and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent Mt. Wilson, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller Inc.</b>				24a. REC'D BY REGISTRAR <b>JUN 4 1957</b>			
ADDRESS <b>-2431 E. Oliver St.</b>				25. REGISTRAR'S SIGNATURE <b>Dorothy Newalls</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILSON LT HOSPITAL

BUREAU V. 3

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6051  
CERTIFICATE OF DEATH

06045  
38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTCH CLIFF NEAR TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTCH CLIFF NEAR TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENARM ROAD</u>		d. STREET ADDRESS <u>GLENARM ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>SISTER MARY HILDA GILVRA</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 26, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>BOSTON MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM MCGILVRA</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL HOGAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SISTER M. PETER FOURIER</u>		Address <u>NOTCH CLIFF MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDITIS</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>52</u> , to <u>JUNE</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>APRIL 9th</u> , 19 <u>57</u> , and that death occurred at <u>645 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. <u>7501 YORK Rd. TOWSON 4, MD</u> <u>6/18/57</u> PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-21-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Gailer</u>		ADDRESS <u>401 S. CONKLING ST. BALTO., 24, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 6/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>Metel Gray</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

MARYLAND

DATE OF DEATH

MARYLAND

DATE OF DEATH

MARYLAND

DATE OF DEATH

MARYLAND

DATE OF DEATH

MARYLAND

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BUREAU V. S.

JUN 24 1957

RECEIVED



6052

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>4yrlmth10dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>McGovern</b> Last <b>McGovern</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>	9. AGE (In years last birthday) <b>82?</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 11</b> , 19 <b>53</b> , to <b>June 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>57</b> , and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-25-57</b> ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Kosch's Sons</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 57</b>		24b. REGISTRAR'S SIGNATURE <b>Wachsler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 1 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6053

## CERTIFICATE OF DEATH

06047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5898 Old Fred. Rd</u>				d. STREET ADDRESS <u>5898 Old Fredrick Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETTA Theresa Mc Wiers</u>				4. DATE OF DEATH Month Day Year <u>6 11 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-04</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>-</u>							
13. FATHER'S NAME <u>George White</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Lucks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Robert S Mc Wiers</u>				Address <u>-5898 Old Fred Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiac Disease</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/17/57</u> , 19 <u>57</u> , to <u>6/11/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/11/57</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.F. Maloney</u>				ADDRESS (Street, city or town, state) <u>57 Winters Lane</u>			
DATE SIGNED <u>6/11/57</u>							
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>				<u>Catonsville, 28. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W Sullivan Jr</u>				ADDRESS <u>Balto</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Overman</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
JUN 6 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		DR. J. H. HARRIS	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10:00 PM		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		MRS. J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
JAMES EARL RAY		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JUN 6 1968		JUN 6 1968		JUN 6 1968		JUN 6 1968		JUN 6 1968		JUN 6 1968	

BUREAU V. 3

JUN 13 1967

RECEIVED

6254

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt, Md. 1623-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSP.</u>				d. STREET ADDRESS <u>9-D Southway</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A.</u> Last <u>McLoughlin</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>T-9-1891, New York</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN Wm McLoughlin</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN Catherine Finn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>072-09-1008</u>			
17. INFORMANT <u>Anna McLoughlin</u>				Address <u>9-D Southway, Greenbelt Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>549.0 Peptic ulcer</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 23</u> , 1957, to <u>June 22</u> , 1957, that I last saw the deceased alive on <u>June 22</u> , 1957, and that death occurred at <u>10:35 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>6-24-57</u>							
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>5801 Aie River Rd</u>				24a. REC'D BY REGISTRAR <u>JUN 27 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

JUN 27 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6055

CERTIFICATE OF DEATH

Reg. Dist. No.

06050

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>30 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 Longview Dr.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Teresa</b> Middle <b>M.</b> Last <b>Meier</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1904</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Tribbe</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <b>Mr. Robert J. Meier Sr.</b> Address <b>123 Longview Dr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno CARCINOMA OF</b> <b>155x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Liver and Gallbladder</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 MONTHS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>February 11, 1957</b> , to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Melvin N. Borden</b>				ADDRESS (Street, city or town, state) <b>5000 BALTIMORE NATIONAL</b>			
PHYSICIAN'S NAME (Type) <b>Melvin N. BORDEN</b>				DATE SIGNED <b>Pilke BALTO 29. Md 6/5/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>				24a. REGISTERED BY <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>DATE</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06051

6056

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BALTIMORE COUNTY HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>C.</b> Last <b>MENKERT</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 17, 1864</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COFFEE MERCHANT</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FREDERICK MENKERT</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss JEAN SISK</b> Address <b>583 Woodbine Ave. Towson</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac-vascular</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **also**, 19**49**, to **June**, 19**57**, that I last saw the deceased alive on **June 25**, 19**57**, and that death occurred at **1:30 AM**, from the causes and on the date stated above.

ACTUAL SIGNATURE **Elizabeth B. Sherrill** M.D. ADDRESS (Street, city or town, state) **Cockeysville, Md.** DATE SIGNED **6/28/57**

PHYSICIAN'S NAME (Type) **Elizabeth B. Sherrill**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 29, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons, Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6/28/57</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Philcoat</b>

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES M. WILSON		JULY 10, 1957	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
MARRIAGE		PLACE OF BIRTH	
M		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
SIGNED BY PHYSICIAN		SIGNED BY REGISTRAR	
J. M. WILSON		J. M. WILSON	

BUREAU V. 3

JUL 2 1957

RECEIVED

6157  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore 20</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 Oak Drive</b>				d. STREET ADDRESS <b>1 100 Stevens Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRIET</b> Middle <b>W.</b> Last <b>MENOCHER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 30, 1871</b>		9. AGE (In years last birthday) yrs. <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Walker</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Cramer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Edward Simmons, Jr. - 15 Tanglewood Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>5 yrs +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>586X gall bladder disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1952</b> , 19____, to <b>June 8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 19, 57</b> , and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Nesbitt, Jr.</b>				ADDRESS (Street, city or town, state) <b>1118 St. Paul St. Baltimore 2 Ind.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>				DATE SIGNED <b>June 12, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tietner &amp; Sons - Balt. Ind.</b>				24a. REC'D BY REGISTRAR <b>DATE 6/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. 3

JUN 13 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6058

## CERTIFICATE OF DEATH

06053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGE'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <b>16 yr 1 month</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEAT PLEASANT 16 x 22</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP.</b>				d. STREET ADDRESS <b>—</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>SUSANNA MESSINGER</b>				4. DATE OF DEATH Month Day Year <b>6 30 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27-1885</b>		9. AGE (In years lost birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Messinger</b>				14. MOTHER'S MAIDEN NAME <b>Catherine White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JOHN MESSINGER-4008-37th ST. MT. RAINIER, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Coronary and generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombosis, left renal artery</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1955</b> , to <b>June 30, 1957</b> , that I last saw the deceased alive on <b>June 30, 1957</b> , and that death occurred at <b>9:00p. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Isadore Turk, M. D.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-1-57</b>			
PHYSICIAN'S NAME (Type) <b>Isadore Turk, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 3 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. A. Leach</b>	

MEDICAL CERTIFICATION

RECEIVED	
JUL 3 1957	
BUREAU V. E.	
John Messinger New York City White	
JUN 30 1957	
Shirley Jones	
JUL 1 1957	
BUREAU V. E.	

RECEIVED

BUREAU A. 2.

1957 3 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06054

## CERTIFICATE OF DEATH

Reg. Dist. No.

6059

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UPPER MARLBORO 16 x 22</b>			
				d. STREET ADDRESS <b>Main Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle Last <b>MICHEL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-30-1888</b>		9. AGE (In years, most birthday) <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done) <b>Meat Market Clerk (Bingly)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groc. Store</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ADAM MICHEL</b>				14. MOTHER'S MAIDEN NAME <b>Magdeline Feile</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL APOPLEXY</b> 934X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 19, 1957</b> to <b>June 24, 1957</b> , that I last saw the deceased alive on <b>June 24, 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Newcomer</b>				M.D. <b>Mt. Wilson, Maryland</b>		DATE SIGNED <b>6/24/57</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony Reilly</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—and HIGHER, 10

## CERTIFICATE OF DEATH

BUREAU V. S.

JUN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06055

6060

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5937 Johnnycake Rd</b>		d. STREET ADDRESS <b>1 5937 Johnnycake Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Middleton</b> Last <b>Middleton</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bedwell</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lloyd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Earl Williams</b>	
17. INFORMANT <b>Earl Williams</b>		Address <b>Middletown, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (b) <b>12 years</b> (c) <b>6 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> M. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10, 1950</b> , to <b>June 10, 1957</b> , that I last saw the deceased alive on <b>June 9, 1957</b> , and that death occurred at <b>3:00</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kennard Yaffe</b>		DATE SIGNED <b>6/12/57</b>	
PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE M.D.</b>		ADDRESS (Street, city or town, state) <b>3101 W Baltimore St.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake City Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 14 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	



RECEIVED



Items 19&20 Film 217 6-26-57

6661

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPS. POINT BALTIMORE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MILTON</b> Last <b>MONGOLD, JR.</b>		4. DATE OF DEATH Month <b>6-11-57</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 26, 1920</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months <b>36</b> Days <b>36</b>	IF UNDER 24 HRS. Hours <b>36</b> Min. <b>36</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP MAFR.</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>R. M. MONGOLD</b>		14. MOTHER'S MAIDEN NAME <b>ZETTIE BOWMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES! WW II</b>		16. SOCIAL SECURITY NO. <b>214-05-5524</b>	
17. INFORMANT <b>MYRIE VANP. MONGOLD - JAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture skull. Fracture, left tibia and fibula, right femur.</b> DUE TO (b) <b>902.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>902.3</b> DUE TO (c) <b>902.3</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>EXPLOSION Fell 90 feet from crane at shipyard</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:40 A.M. 6-11-57</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beth.Sp.Pt.Syd.Inc. Sparrows Point 19, Balto.Co.</b>		20f. (City or town) (County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>MB Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-11-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-15-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>KEYSER CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Smith, Hurdle, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 14 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6888 Thompson RD.  
Dundalk 22

BUREAU V. S.

JUN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06057

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN lb <b>3Y01-4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital-Beth. Steel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2029 E. Eager Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sanford</b> <b>N.M.N.</b> <b>MORTON</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-98</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Narrow Gauge Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>Nicie Morton</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-07-3451</b>		17. INFORMANT <b>Harvey Benson</b> Address <b>1445 P. Benson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decapitation-Evisceration-Multiple compound fractures-Complete crushing of body.</b> DUE TO (b) <b>912.3</b> Conditions, if any, which gave rise to immediate cause (c) <b>stating the underlying cause lost.</b> DUE TO (c) <b>stating the underlying cause lost.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fell under narrow gauge drag.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>11:25</b> <b>6-24-57</b> Hour, p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B. S. Plant</b>	20f. (City or town) <b>Sp. Pt.</b> (County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-25-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 28</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Calvary</b>	22d. LOCATION (City, town, or county) (State) <b>AA, Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>		24a. RECEIVED BY REGISTRAR <b>6/25/57</b>	24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 3 1957

RECEIVED

John R. [illegible]  
[illegible]

John R. [illegible]  
[illegible]

John R. [illegible]  
[illegible]

06058

6963

# CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN lb <b>8 1/2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 3801-4</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>1525 West Baltimore, Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Dianne</b> Middle <b>Eileen</b> Last <b>Mowbrey</b>		4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>57</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/14/47</b>		9. AGE (In years last birthday) <b>9 10 yrs.</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Robert H. Mowbrey</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude May Beach Ford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rosewood Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Aspiration</b> <b>351x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hydranencephaly</b> DUE TO (c) <b>Early infant brain damage</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Taiocy, cerebral palsy</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/19/48</b> , 19____, to <b>6/14/57</b> , 19____, that I last saw the deceased alive on <b>6/14/57</b> , 19____, and that death occurred at <b>7:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Rich. Lindenber (Phy.)</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Rich. Lindenber</b>				<b>Rosewood State Training School</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
				<b>St. Mary's Cemetery</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank D. Howell, Baltimore</b>				24a. REC'D BY REGISTRAR DATE <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elise</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



**BUREAU V. S.**

JUN 19 1957

RECEIVED



6064

CERTIFICATE OF DEATH

06059

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4303 Soth Avenue</u>		d. STREET ADDRESS <u>1 4303 Soth Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Eupha</u> Middle <u>A.</u> Last <u>Mullan</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5th</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>James Farmer</u>		14. MOTHER'S MAIDEN NAME <u>Eupha Maxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Eupha Mullan, 4303 Soth Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 2, 19 57</u> to <u>June 5, 19 57</u> , that I last saw the deceased alive on <u>June 5, 19 57</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6232 Belair Rd. Balto. 6, Md.</u> DATE SIGNED <u>June 5, 1957</u>			
ACTUAL SIGNATURE <u>Adam G. Swiss</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. DANIEL SWISS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/8/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Deacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Use One Side

1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. TIME OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF BURIAL PLACE	
17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06060

6965

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON #4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON #4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1106 Stevenson Lane</u>		d. STREET ADDRESS <u>1106 Stevenson Lane</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>AMELIA</u> Middle <u>MYERLY</u> Last		4. DATE OF DEATH <u>June</u> Month <u>16</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1893</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F Rappé</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George H Myerly</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF SIGMOID COLON</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>June 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>57</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A Pillsbury</u>		ADDRESS (Street, city or town, state) <u>TIMONIA, MD</u> DATE SIGNED <u>6/16/57</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>June 19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Prospect Hill</u>		<u>Towson Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Jenkins</u>		ADDRESS <u>Amo 4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

0.0010

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar or removal.

VS. A15ME(5)  
5M 9/55

6066

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06061

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS PT - 19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 EDMERE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jones Creek -</u>		d. STREET ADDRESS <u>2529 Schoolhouse Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID LEE MYERS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9/44</u>
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leslie I. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Verna Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Verna Brooks</u>		Address <u>2529 School House Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>                    </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from Inner Tube in Jones Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>4</u> <u>6-22-57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>                    </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. City or town (County) (State) <u>Sp. Pt. - Balto Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Vennella Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Blackburg, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM F. FURBER, PUNDALE, MD.</u>		24. REC'D BY REGISTRAR DATE <u>6/24/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Lester L. Lister</u>			



# MASSACHUSETTS DEPARTMENT OF HEALTH-BALDWIN II MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**RECEIVED**  
JUN 25 1957  
BUREAU V. 8



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file or for burial/cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06062

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1515 Park Ave. #17</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wheeler</b> Middle <b>Estes</b> Last <b>Nicholson</b>				4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>4</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tiny Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>223-20-4059</b>		17. INFORMANT <b>Mrs. Ruth L. Nicholson, 1515 Park Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>420.1</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> <b>NONE</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>		EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-24-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>JUN 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Larkins</b>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU V. S.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

UN 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06063 41

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>IN BACK RIVER - ADJACENT</u> <u>4233 LYNHURST ROAD</u>		d. STREET ADDRESS <u>1 4233 LYNHURST R L</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINA LYNN NODONLY</u>		4. DATE OF DEATH Month Day Year <u>6-11-57</u> 19 <u>57</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 JULY 1954</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>ALEXANDER NODONLY</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN J. NODONLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>A. NODONLY</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Choked wound 17" into water.</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:00 a.m. 6-11-57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BACK RIVER</u>		20f. (City or town) (County) (State) <u>MD Sp. Pt. 9 BALTO - Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Mackay, Dundalk 22, MD</u>		24a. REC'D BY REGISTRAR <u>John F. Kelly</u>	
24b. REGISTRAR'S SIGNATURE <u>John F. Kelly</u>		DATE <u>JUN 14 1957</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUN 14 1957  
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6068

## CERTIFICATE OF DEATH

Reg. Dist. No.

06064-33-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>84 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Vernon Rd.</u>		d. STREET ADDRESS <u>Vernon Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Norris</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 1872</u> yrs. <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm H Norris</u>		14. MOTHER'S MAIDEN NAME <u>Emma L Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Leonce B. Norris</u> Address <u>White Hall Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450. generalized Arterio-sclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>May</u> Day <u>27</u> Year <u>1957</u> Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 27, 1957</u> to <u>June 2, 1957</u> , that I last saw the deceased alive on <u>June 2, 1957</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton Md.</u> DATE SIGNED <u>6/7/57</u>	
PHYSICIAN'S NAME (Type) <u>R. M. FRANCE</u>		<u>PARKTON, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hartenstein</u> ADDRESS <u>New Freedom Rd.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>6/5/57</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Burton</u>



JUN 6 1957

RECEIVED



1

## INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06065

## 6869 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	LENGTH OF STAY (in this place) <u>3 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE 3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Nursing Home</u>		STREET ADDRESS (If rural give location) <u>217 S. HILTON ST.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>PEARL</u> (Middle) <u>VIOLA</u> (Last) <u>NUFFER</u>		(Month) <u>6</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 26, 1894</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALUEY DANFORTH</u>		14. MOTHER'S MARRIAGE NAME <u>IDA M. IDLESBERGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>Doris BRYAN 217 S. HILTON ST.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
422.1 IMMEDIATE CAUSE (A) <u>arteriosclerotic C.V.D.</u>			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MAR</u> , 19 <u>54</u> , to <u>JUNE 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 17</u> , 19 <u>57</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>George L. Schuch</u>		ADDRESS (Street, city, town, state) <u>3325 Frederick Ave Md.</u>	
DATE <u>JUN 20 57</u>		DATE SIGNED <u>6/18/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>6-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>	
LOCATION (City, town, or county) <u>ELK RIDGE Md.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schuch</u>	
ADDRESS <u>2101 Frederick Ave</u>			

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE 12

AT NEW YORK, COUNTY OF NEW YORK, DECEASED

DOCTOR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

ICD-9 CODE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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BUREAU V. S.

JUN 20 1957

RECEIVED

6070

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5mths 1dy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>FRANK</u> Last <u>O'Donnell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1870, Oct. 15</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>3</u> Min.	IF UNDER 24 HRS. Months <u>8</u> Days <u>8</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown Soldier Ret. U.S. Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland ENGLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES #0-181-226</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Mrs. Chas. Parks - 3552 Horton Avenue - 25</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>daughter</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan, 11</u> , 19 <u>57</u> , to <u>June 18</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>3:25 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				DATE SIGNED <u>6-19-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				ADDRESS (Street, city or town, state) <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hgwy A.P.C. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Bone</u>				ADDRESS <u>4001 Ritchie Hwy</u>		24a. REC'D BY REGISTRAR <u>DATE 6/24/57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>							

600

BUREAU V. 31

JUN 25 1957

RECEIVED

6071

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>10mths8dys</u>		d. STREET ADDRESS <u>2003 W. Pratt St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>O'hara</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio vascular disease</u> DUE TO (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1 female brain disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 17, 1957</u> , to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>6-21-57</u>			
ACTUAL SIGNATURE <u>John Vasconcellos</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN VASCONCELLOS</u> <u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u> ADDRESS <u>2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Andrew</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 24 1957

RECEIVED

6072

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	c. LENGTH OF STAY IN 1b <u>62 yrs. x 2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9301 Old Harbor Rd.</u>		d. STREET ADDRESS <u>9301 Old Harbor Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Elbert</u> Last <u>Old</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24 / 1877</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTH PLACE (State or foreign country) <u>S. Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Chastine Old</u>		14. MOTHER'S MAIDEN NAME <u>May Belle Crawford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sons</u>		Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility &amp; Cachexia</u> <u>161X</u> DUE TO (b) <u>Agex</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Possible Ca of Larynx</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>56</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasiuk</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Harbor Rd Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		DATE SIGNED <u>6/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meade</u>		ADDRESS <u>Don 805 N. Calvert St.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be filed with the funeral director, and the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

COUNTY OF MARYLAND DISTRICT OF COLUMBIA		DECEASED NAME	
PLACE OF DEATH		SEX	
DATE OF DEATH		TIME OF DEATH	
PLACE OF BIRTH		AGE	
OCCUPATION		CAUSE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

**BUREAU V. S.**

JUN 18 1957

**RECEIVED**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06069

6973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Md. Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hoods Nursing Home</u>		d. STREET ADDRESS <u>12 Melvin Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>T.</u> Last <u>Olmer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Joseph Olmer</u>		14. MOTHER'S MAIDEN NAME <u>Regina Kroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Miss Regina Olmer</u>		Address <u>12 Melvin Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident - Multiple</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Embolic Phenomenon</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/17</u> , 19 <u>57</u> to <u>6/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor F. King</u> M.D.		ADDRESS (Street, city or town, state) <u>715 Frederick Ave</u>	
DATE SIGNED <u>6/19/57</u>			
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home</u>		ADDRESS <u>Catonsville Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, and cause of death. The form is partially filled out with handwritten text.

RECEIVED  
JUN 20 1967  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6074 Item 12 Film 216 6-12-57 et  
CERTIFICATE OF DEATH

06070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2113 Lorraine Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSARIO</b> Middle <b>PAPALE</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>2nd.</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman - Cement finishing work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Italy</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>GIUSEPPE PAPALE</b>		14. MOTHER'S MAIDEN NAME <b>MARIA SA/VO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-015740</b>	
17. INFORMANT <b>Mr. Edgar Gise,</b>		Address <b>2113 Lorraine Avenue Baltimore 7, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Magnifying of lungs, bilateral</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6/2</b> , 19 <b>56</b> , to <b>6/2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/2</b> , 19 <b>57</b> , and that death occurred at <b>5:45</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Joseph Robert Liberto</b>		M.D. <b>3508 Bank St, Baltimore 24, Md.</b> <b>6/4/57</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH ROBERT LIBERTO</b>		<b>BALTIMORE 24, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 6, 1957.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>		24. REG. DIST. REGISTRAR'S SIGNATURE <b>Dr. Hon. E. Martin</b>	

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1912	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Date of Death		Time of Death	
Carpenter		High School		June 1, 1957		10:30 AM	
Physician		Hospital		Place of Death		Signature of Physician	
Dr. J. Smith		St. Mary's Hospital		Home		[Signature]	
Coroner		Burial Place		Name of Undertaker		Signature of Undertaker	
John Doe		Catholic		J. Doe		[Signature]	
Date of Burial		Name of Minister		Signature of Minister		Signature of Coroner	
June 3, 1957		Rev. J. Doe		[Signature]		[Signature]	

BUREAU V. S.

JUN 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6075

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drexel Hill</b> <b>75X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>44 Gorsuch Road</b>				d. STREET ADDRESS <b>662 Drexel Brook Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>E.</b> Middle <b>LEWIS</b> Last <b>PARRY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 6, 1895</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Warnet Dental Mfg. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Parry</b>		14. MOTHER'S MAIDEN NAME <b>Catherine (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Robert Cross, 44 Gorsuch Rd., Timonium, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>022X</b> IMMEDIATE CAUSE (a) <b>Ruptured Aortic Aneurysm.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6/4/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Great Valley Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Malvern, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>JUN 6 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. F. Guerin</b>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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171

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6976  
CERTIFICATE OF DEATH

060722  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armatost Nursing Home</b>			d. STREET ADDRESS <b>1707 E. Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DOCK</b> Middle <b>E.</b> Last <b>PATRICK</b>			4. DATE OF DEATH Month <b>June 14,</b> Day <b>1957</b> Year <b>19</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1867</b>		9. AGE (In years last birthday) <b>89</b> IF UNDER 1 YEAR: Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min. <b>89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Gardner - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Patrick</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Stetzer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Bronchial Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>10 yrs</b> (c)					INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2501 York Rd</b>	
20f. (City or town) <b>Towson</b>		20g. (County) <b>Towson</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>June 9, 1957</b> to <b>June 14, 1957</b> that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>1707 E. Joppa Rd</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>Charles F O'Donnell</b> M.D. <b>2501 York Rd</b> DATE SIGNED <b>6/17/57</b> PHYSICIAN'S NAME (Type) <b>Charles F O'Donnell - Towson #4 Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	
22d. LOCATION (City, town, or county) <b>Parkville, Maryland</b>		22e. (State) <b>Md.</b>		22f. (Country) <b>USA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Dunk Soro</b>		ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 20 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mark Gray</b>					



# CERTIFICATE OF DEATH

HEALTH AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 2

JUN 20 1957

RECEIVED

Date of Death June 14, 1957		Place of Death Baltimore	
Name of Deceased William H. ...		Sex Male	
Date of Birth July 1, 1887		Race White	
Usual Residence ...		Cause of Death ...	
Signature of Physician ...		Signature of Registrar ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)  
5M 9/55

6077

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1835 S. Charles Street</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Clarence Payne</b>				4. DATE OF DEATH Month Day Year <b>June 19 19 57</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John William</b>			14. MOTHER'S MAIDEN NAME <b>Rose Morgan</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fractured skull</b> (c) <b>cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. allegedly fell and injured head about first of May, 1957 while entering his apartment.</b>						
20c. TIME OF INJURY Hour o. m. Month, Day, Year <b>unknown 5-2-57 19?</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore, Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b> EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6-19-57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>6/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		22d. LOCATION (City, town, or county) (State) <b>Rifene Highway</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. J. Foley &amp; Sons</b>				ADDRESS <b>1318 Light</b>		24a. REC'D BY REGISTRAR <b>Redman</b>		
				24b. REGISTRAR'S SIGNATURE				

INVEST AND STATE DEPARTMENT OF HEALTH - BUREAU V. 2  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUN 21 1957  
BUREAU V. 2

6078

## CERTIFICATE OF DEATH

06074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md. 02x02</b>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1040 Fitzallen Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sophie</b> Middle <b>OCCENS</b> Last <b>Petrica</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1899</b>
9. AGE (In years last birthday) <b>78?</b> yrs.		IF UNDER 1 YEAR Months <b>78?</b> Days <b>78?</b> Hours <b>78?</b> Min. <b>78?</b>	IF UNDER 24 HRS. Months <b>78?</b> Days <b>78?</b> Hours <b>78?</b> Min. <b>78?</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>2-19-81-6283</b> INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with failure</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>_____</b> m. <b>19</b> p. m. <b>_____</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f. (City or town) (County) (State) <b>_____</b>	
21. I certify that I attended the deceased from <b>June 19, 19 57</b> , to <b>June 29, 19 57</b> , that I last saw the deceased alive on <b>June 29, 19 57</b> , and that death occurred at <b>6 A.</b> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>_____</b>			
ACTUAL SIGNATURE <b>Charles Ward</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES WARD M.D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy G &amp; G Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard A Fink</b>		ADDRESS <b>2200 Borne Rd</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 2 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Form No. 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

**RECEIVED**  
JUL 2 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06075

6079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND <b>MD.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>58 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave.</b>				d. STREET ADDRESS <b>610 Woodington Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alfred E. Pile</b>		First <b>Alfred</b> Middle <b>E.</b> Last <b>Pile</b>		4. DATE OF DEATH <b>June 16/57</b>		Month <b>June</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19, 1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contracting Engineer—Consolidated</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>France</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>-----Pile</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife, Bertha Pile</b> Address <b>610 Woodington Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple metastasis from carcinoma of prostate</b> <b>177x</b> DUE TO (b) <b>prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>prostate</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 5, 1955</b> , to <b>June 16, 1957</b> , that I last saw the deceased alive on <b>June 16, 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b> DATE SIGNED <b>June 17, 1957</b>							
ACTUAL SIGNATURE <b>George A. Knipp</b>				M.D. <b>4116 Edmondson Avenue</b> <b>June 17, 1957</b>			
PHYSICIAN'S NAME (Type) <b>George A. Knipp, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>June 18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>				ADDRESS <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>June 19 57</b> 24b. REGISTRAR'S SIGNATURE <b>Paul Smith</b>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

BUREAU V. 81

JUN 19 1957

RECEIVED

6080

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2419 Lodge Forest Drive</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ford Lodge Nursing Home</u>				d. STREET ADDRESS <u>112 N. Haven St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY C. PONS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Calvert Club</u>				11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Edward Westervelt</u>				14. MOTHER'S MAIDEN NAME <u>Catherine East</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>522X</u>				16. SOCIAL SECURITY NO. <u>214-22-0368</u>			
17. INFORMANT <u>Helen C. Hunt - 102 N. Haven St</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Apoptotic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Accident</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>522X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>56</u> , to <u>June 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Means</u> M.D.				ADDRESS (Street, city or town, state) <u>520 S. St. Balto, Md</u>			
DATE SIGNED <u>6/18/57</u>							
PHYSICIAN'S NAME (Type) <u>James T. Means</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 20, 57</u>		<u>Balto Cem</u>		<u>North Ave Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller</u>				ADDRESS <u>2431 E. Olney St</u>			
24a. REC'D BY REGISTRAR <u>21</u>				24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farkes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6981

## CERTIFICATE OF DEATH

Reg. Dist. No.

06077 38

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	c. LENGTH OF STAY in 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (1K)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2918 Grindon La</u>	d. STREET ADDRESS <u>2918 Grindon La</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William John Reichart</u>		4. DATE OF DEATH <u>June 29 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 April 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Reichart</u>		14. MOTHER'S MAIDEN NAME <u>Unk "Germany"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219034168</u>	
17. INFORMANT <u>Wife</u>		Address <u>2918 Grindon La</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial degeneration</u> (c) <u>Degeneration of Aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1955</u> to <u>June 1957</u> , that I last saw the deceased alive on <u>May 19 1957</u> and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasir Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Harford Rd. Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIR JR.</u>		DATE SIGNED <u>6/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 29, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Rd. Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24a. REC'D BY REGISTRAR <u>DATE JUL 1 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>L. B. M. Bacon</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED <i>William J. Williams</i>		AGE <i>45</i>	
SEX <i>Male</i>		DATE OF BIRTH <i>Nov 1, 1912</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		DATE OF DEATH <i>Nov 1, 1957</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		PLACE OF DEATH <i>Home</i>	
MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	
MARRIAGE <i>Married</i>		SPOUSE <i>Martha Williams</i>	
CHILDREN <i>3</i>		SIGNED BY <i>Dr. J. H. Smith</i>	
DATE OF SIGNATURE <i>Nov 1, 1957</i>		PLACE OF SIGNATURE <i>Baltimore, Md.</i>	

BUREAU V. 1

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6082

## CERTIFICATE OF DEATH

Reg. Dist. No.

060784

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>11 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3327 Foster Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>A.</b> Last <b>REINSFELDER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 4, 1922</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John A. Reinsfelder</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Schlee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO. <b>218-14-6396</b>			
17. INFORMANT <b>Clinical Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTRO-INTESTINAL HEMORRHAGE</b> <b>201x</b> DUE TO <b>HODGKIN'S DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>9 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>578x</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 31</b> , 19 <b>57</b> , to <b>June 10</b> , 19 <b>57</b> . and that death occurred on <b>June 10</b> , 19 <b>57</b> , at <b>3:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/10/57</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, D., Chief, Medical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Hearts Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler, Inc., 403 South Wolfe Street,</b> <b>Baltimore, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 12 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Lawson L. Larkins</b>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

RECEIVED  
JUN 12 1957  
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6083

## CERTIFICATE OF DEATH

Reg. Dist. No.

06979

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>229 Blakeney Road</b>		d. STREET ADDRESS <b>229 Blakeney Road</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>REMESCH</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-1882</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hochschild Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Remesch</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-01-2330</b>	
17. INFORMANT <b>Frank S. Remesch..229 Blakeney Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>1 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 15, 1953</b> to <b>June 10, 1957</b> , that I last saw the deceased alive on <b>June 10, 1957</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1945 West Baltimore Street 6/ /57</b>			
ACTUAL SIGNATURE <b>James R. Grabill</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JAMES R. GRABILL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 14/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Will Wipacot</b>		24a. REC'D BY REGISTRAR <b>1300 Eutaw Pl. 17</b>	
24b. REGISTRAR'S SIGNATURE <b>Will Wipacot</b>		DATE <b>June 14 57</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1891		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JULY 14 1957		HOME		BALTIMORE		MARYLAND		UNITED STATES		JULY 14 1957		HOME		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		3		2		2	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF CORONER		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS	
J. H. HARRIS		JULY 14 1957		J. H. HARRIS		JULY 14 1957		J. H. HARRIS		JULY 14 1957		J. H. HARRIS		JULY 14 1957		J. H. HARRIS	

BUREAU K. 1

JUN 14 1957

RECEIVED



6084  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>54</b> <b>Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 2126 Firethorne Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Ida Elizabeth Rice</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1867</b>		9. AGE (In years last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard Thomas Tydings</b>				14. MOTHER'S MAIDEN NAME <b>Mary Main</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles Rice, 2126 Firethorne Rd. Middle River</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Blunt force trauma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior Septal Heart Disease</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 21</b> , 19 <b>57</b> , to <b>June 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 2</b> , 19 <b>57</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Robert J. Lyden</b> DATE SIGNED <b>6/26/57</b>							
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dover Methodist Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>				24a. REC'D BY REGISTRAR DATE <b>6/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Edith J. Lyden</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. No. 100

Name of Deceased		Date of Death	
John Doe		June 27, 1957	
Age		Sex	
45		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
Maryland		Baltimore, Maryland	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Contributing Cause		Hypertension	
Date of Report		Signature of Registrar	
June 28, 1957		John Doe	
Signature of Physician		Signature of Coroner	
John Doe		John Doe	

BUREAU V. 2

JUN 27 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6485

## CERTIFICATE OF DEATH

06081

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Calonsville</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Friendship</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pine</u>				STREET ADDRESS (If rural give location) <u>13X0-2</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Albert R. Ridgely</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>6 21 1957</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>12-6-76</u>	<b>9. AGE last birthday</b> <u>80</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shoe Store</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Charles W. Ridgely</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Frank E. Ridgely</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Edith M. Ridgely - West Friendship</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Parkinsonism</u>						<u>1231</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>491X</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>9-9</u> , 19 <u>49</u> , to <u>6-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Wilmer K. Gullager</u>				<b>DATE SIGNED</b> <u>M.D. 6209 Frederick Ave. Balt. 28, Md. 6-21-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>6-24-57</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt View</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Howard Co., Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Albert R. Ridgely</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Haight</u>		<b>ADDRESS</b> <u>West Friendship, Md.</u>	
<b>DATE</b> <u>JUN 26 '57</u>							

THE UNIVERSITY OF CHICAGO

RECEIVED

6086

## CERTIFICATE OF DEATH

06082

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2618 Linwood Ave</u>		d. STREET ADDRESS <u>1 2618 Linwood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>ROBELING</u> Middle <u>0</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 17-1892</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Rubeling</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET KLOOS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>John Rubeling</u> Address <u>2618 Linwood Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary thrombosis.</u> DUE TO (b) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X Cerebral Accidents 23 yrs ago.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>57</u> , to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>57</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D.		DATE SIGNED <u>6-14-57</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SCHWARTZ LEM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES F. EVANS &amp; SON</u> ADDRESS <u>118 W. MC. KUYER AVE</u>		24a. REC'D BY REGISTRAR <u>JUN 17 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Burns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. B.

1957 21 NFI

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 18. Film 218 7-18-57 ans  
Item 7 Film 6217 7-11-57 et

Item 18. Film 218 7-18-57 ans  
5942

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06083

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN lb <b>53</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>117 Main Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>117 Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCIOUS</b> Middle <b>ROBINSON</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/04</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saborer</b>		9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTH PLACE (State or foreign country) <b>South Carolina, U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lucious Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Anna Kirksey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>2</b>		16. SOCIAL SECURITY NO. <b>249-10-4526</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/17/57</b>	
22a. BURIAL, CREMATION, EMOVAL (Specify)		22b. DATE THEREOF <b>June 22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eastley S.C.</b>		22d. LOCATION (City, town, or county) (State) <b>Eastley S.C.</b>	
FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Williams</b>		ADDRESS <b>1701 N. Bond St.</b>	
24a. REC'D BY REGISTRAR <b>7/1/57</b>		24b. REGISTRAR'S SIGNATURE <b>Tom Kelly</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06084

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO TIMONIUM</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>47 BELFAST RD</b>				d. STREET ADDRESS <b>49 OAKWAY RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CALVIN</b> Middle <b>A.</b> Last <b>RODGERS</b>				4. DATE OF DEATH Month <b>6</b> - Day <b>25</b> - Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-84</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLASTERER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-8727</b>		17. INFORMANT <b>GENEVA G RODGERS</b>		Address <b>49 OAKWAY RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Sudden Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>6-28-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MTZION</b>	
22d. LOCATION (City, town, or county) (State) <b>BALTO CO.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Schenck</b>				ADDRESS <b>360 Chestnut Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Rehearn</b>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED  
JUN 28 1957  
BUREAU V. S.



# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6088

## CERTIFICATE OF DEATH

06085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. LENGTH OF STAY IN 1b <b>4 1/2 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. STREET ADDRESS <b>2916 Hartford Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Julius</b> Last <b>Rose Jr.</b>				4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/4/1901</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>4</b> Min.		11. IF UNDER 24 HRS. Months <b>3</b> Days <b>10</b> Hours <b>4</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Otto J. Rose</b>				14. MOTHER'S MAIDEN NAME <b>Georgina Reisinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b> DUE TO (b) <b>11 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>002x</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/29</b> , 19 <b>57</b> , to <b>6/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/14</b> , 19 <b>57</b> , and that death occurred at <b>6:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b>							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5805 Hartford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>6/18/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>							

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 1, 1900</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
MARRIAGE <i>Married</i>		DATE OF DEATH <i>June 19, 1957</i>		PLACE OF DEATH <i>Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>	
EDUCATION <i>High School</i>		RELIGION <i>None</i>		MARITAL STATUS <i>Married</i>	
FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>John Doe</i>		FAMILY HISTORY <i>None</i>	
PREVIOUS ILLNESS <i>None</i>		TREATMENT <i>None</i>		HISTORICAL DATA <i>None</i>	
PHYSICIAN'S SIGNATURE <i>John Doe</i>		DATE <i>June 19, 1957</i>		PLACE <i>Baltimore, Md.</i>	
HOSPITAL NAME <i>John Doe</i>		ADDRESS <i>John Doe</i>		CITY <i>John Doe</i>	
STATE <i>John Doe</i>		ZIP CODE <i>John Doe</i>		COUNTRY <i>John Doe</i>	
DECEASED'S SIGNATURE <i>John Doe</i>		DATE <i>John Doe</i>		PLACE <i>John Doe</i>	
HOSPITAL NAME <i>John Doe</i>		ADDRESS <i>John Doe</i>		CITY <i>John Doe</i>	
STATE <i>John Doe</i>		ZIP CODE <i>John Doe</i>		COUNTRY <i>John Doe</i>	

**RECEIVED**  
JUN 19 1957  
BUREAU V. S.

6089

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>447 Range Rd.</b>				d. STREET ADDRESS <b>4501 Ridge Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>F.</b> Last <b>RULLMAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>-</b>							
13. FATHER'S NAME <b>Frederick Rullman</b>				14. MOTHER'S MAIDEN NAME <b>Alice V. Elliott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Miss Edna E. Rullman - 4501 Ridge Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Messenic Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6/5</b> , 19 <b>57</b> , to <b>6/6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/6</b> , 19 <b>57</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balto, Md.</b> DATE SIGNED <b>6/7/57</b> ACTUAL SIGNATURE <b>W. M. Smith</b> M.D. <b>6305</b> PHYSICIAN'S NAME (Type) <b>Balto 12</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor &amp; Sons - Balto 17</b>				24a. REC'D BY REGISTRAR DATE <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 1

JUN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6090 CERTIFICATE OF DEATH

06087

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 Overbrook Rd.</u>			d. STREET ADDRESS <u>17 Overbrook Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lillie M. Sauer</u>			4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6. ?</u>		9. AGE (In years lost birthday) <u>49 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Sauer</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Schley</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Mrs. Reddick - 17 Overbrook Rd</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cordia-Vascular Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December</u> , 19 <u>56</u> , to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Dennis Laughlin</u>		DATE SIGNED <u>June 13 1957</u>			
PHYSICIAN'S NAME (Type) <u>D.C. Mac Laughlin</u>		ADDRESS (Street, city or town, state) <u>4508 Edmondson Village</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
22d. LOCATION (City, town, or county) <u>Balto.</u>		22e. (State) <u>md.</u>		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd</u>		24a. REC'D BY REGISTRAR <u>W. H. H. H.</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JUN 18 57</u>			



Received by  
 Mr. T. J. [unclear]  
 1911

BUREAU V. S.

JUN 18 1957

RECEIVED

John Garner  
 female white  
 17 Overbrook Rd.  
 Catonsville  
 Md.  
 13 27  
 June 13 27  
 17 Overbrook Rd.  
 Catonsville  
 Md.  
 13 27

6091

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nurs. Ho. 812 Register Ave.</b>		d. STREET ADDRESS <b>300 Goodwood Gardens</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNE</b> Middle <b>HOGE</b> Last <b>SAVAGE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D. C.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wm. Schofield Hoge</b>		14. MOTHER'S MAIDEN NAME <b>Mary Barlow Stearns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Frederick A. Savage, Jr. - Cockeysville,</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO 10 yrs. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1957</b> to <b>June 29, 1957</b> ; that I last saw the deceased alive on <b>June 29, 1957</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F O'Donnell</b> M.D.		ADDRESS (Street, city or town, state) <b>7501 York Rd</b> DATE SIGNED <b>7/1/57</b>	
PHYSICIAN'S NAME (Type) <b>Charles F O'Donnell M.D. Gibson #4 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cooperstown, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto</b>		24a. REC'D BY REGISTRAR <b>DATE 7/2/57</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Mabel Hayes</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06089

6092

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>			d. STREET ADDRESS <b>1041 Hillen Street</b>		
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Henry</b> Last <b>Scheper</b>			4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1957</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/1881</b>		9. AGE (In years last birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Frank Scheper</b>			14. MOTHER'S MAIDEN NAME <b>Augustas Kruger</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-9505</b>		17. INFORMANT <b>Admission Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis - Generalized</b> DUE TO (c) <b>10 yrs</b>					INTERVAL BETWEEN ONSET AND DEATH <b>60 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Dec 6, 1955</b> to <b>JUNE 19, 1957</b> that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Charles F O'Donnell</b> M.D.			ADDRESS (Street, city or town, state) <b>7501 York Rd</b>		
PHYSICIAN'S NAME (Type) <b>Charles F O'Donnell M.D.</b>			DATE SIGNED <b>6/20/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
22d. LOCATION (City, town, or county) (State) <b>Balto., Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Amos</b>			ADDRESS <b>4905 York Rd</b>		
24a. REC'D BY REGISTRAR <b>2157</b>		24b. REGISTRAR'S SIGNATURE <b>Out</b>			

JUN 21 1957

RECEIVED



6093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06090

Item 12:G217 6-28-57 L.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN IB <u>25yr8mth9dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bruno</u> Middle <u>C</u> Last <u>Schramm</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898 - 12/25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>58?</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized U.S. citizen</u>	
13. FATHER'S NAME <u>unknown Paul Schramm</u>		14. MOTHER'S MAIDEN NAME <u>unknown Charlotte Schramm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stella Wachsler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL 6-21-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck</u>		24a. REC'D BY <u>6-21-57</u> 24b. REGISTRAR'S SIGNATURE <u>Carl Kuck</u>	

JUN 24 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6094 CERTIFICATE OF DEATH

Reg. Dist. No. 48

07241

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Falls</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>x2 Upper Falls</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Schutz</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28 1872</b>	
9. AGE (In years less birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Upper Falls, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick J. Schutz</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Orem</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Evelyn E. Schutz, Upper Falls, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cardiac Insufficiency</b> DUE TO (c) <b>10 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 14, 1957</b> to <b>June 14, 1957</b> that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter M. Hammatt</b>				ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>			
DATE SIGNED <b>June 16 1957</b>				DATE SIGNED <b>June 16 1957</b>			
PHYSICIAN'S NAME (Type) <b>Walter M. Hammatt</b>				DATE SIGNED <b>June 16 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Franklin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Franklinville, Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard P. McKenna</b>				ADDRESS <b>Abingdon Rd</b>		24a. REC'D BY REGISTRAR <b>W. M. Hammatt</b>	
DATE <b>6/17-57</b>				24b. REGISTRAR'S SIGNATURE		DATE <b>6/17-57</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Liberty Rd.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Liberty Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dale</u> Middle <u>NORMAN</u> Last <u>SHAW</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/57</u>	9. AGE (In years last birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>—</u> Hours <u>—</u> Min.	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Dale Norman Sutton</u>				14. MOTHER'S MAIDEN NAME <u>Josana Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Josana Shaw, White Hall, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO <u>924.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was sleeping with grandmother who rolled on him</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Balto</u>		20f. (City or town) (County) (State) <u>Balto</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Buried June 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Kirkwood Shopton, Balt. Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin G. Kutz, Jr., Baltimore, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>6/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Martin</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BARNORSE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 26 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6096

## CERTIFICATE OF DEATH

Reg. Dist. No.

06092

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. LENGTH OF STAY IN 1b <b>46 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2506 Poplar Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>WELFORD</b> Middle <b>D.</b> Last <b>SHELHOSS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 20, 1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co., Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Shelhoss</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 213-03-9124</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS OF THE OMENTUM, MESENTERY AND ABDOMINAL WALL</b> 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ADENOCARCINOMA OF GALL BLADDER</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 23</b> , 19 <b>57</b> , to <b>June 8</b> , 19 <b>57</b> , and that death occurred at <b>11:15 P.M.</b> , from the causes and on the date stated above. <b>Chien Wei Lan</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>6/9/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>				<b>6/9/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Funeral Home, 8728 Liberty Rd., Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lauron L. Fackey</b>	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to the quality of the scan.

BUREAU V. 3

JUN 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6097

Item 4 FilmG217 7-5-57 et

CERTIFICATE OF DEATH

06093

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2407 Light Foot Drive</u>		d. STREET ADDRESS <u>2407 Light Foot Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last		4. DATE OF DEATH <u>June 29,</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTH PLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Johanan</u>		14. MOTHER'S MAIDEN NAME <u>Etta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Stanley Babin</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Bacterial myocardial infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/18</u> , 19 <u>57</u> , to <u>6/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2320 Eastwood Place</u> DATE SIGNED <u>Milton B. Kirsh</u>			
ACTUAL SIGNATURE <u>Milton B. Kirsh</u> M.D.			
PHYSICIAN'S NAME (Type) <u>MIKTON B. KIRSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>2</u> 1957	
		24b. REGISTRAR'S SIGNATURE <u>Anthony Newell</u>	

CERTIFICATE OF DEATH

Internal tuberculosis infection 10 days

BUREAU V. S.

JUL 2 1957

RECEIVED



6098

CERTIFICATE OF DEATH

Reg. Dist. No.

06094

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u> x2 <u>Anneslie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 Anneslie Rd.</u>		d. STREET ADDRESS <u>1602 Anneslie Road</u>	
3. NAME OF DECEASED (Type or print) <u>MATTHEW JAMES SMITH, SR</u>		4. DATE OF DEATH <u>June 8 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1895</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew James Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-8339</u>	
17. INFORMANT <u>Mrs. Katherine E. Smith</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>ON JUNE 8, 1957</u> , to <u>          </u> , 19 <u>          </u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>57</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Glickard M.D.</u>		DATE SIGNED <u>6/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Balto. 12, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Red.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Anderson #925 York</u>		24a. REC'D BY REGISTRAR <u>6/10/57</u>	
ADDRESS <u>          </u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 10, 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED  
JUN 11 1957  
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6099

## CERTIFICATE OF DEATH

06095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 Maiden's Choice Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>R.</b> Last <b>SNIBBE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Vt.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Benj. F. Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Fiske</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Robert M. Snibbe - 14 Hillside Ave.</b>		Address <b>Port Washington, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Intestines</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>18 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1942</b> to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		ADDRESS (Street, city or town, state) <b>6205 Frederick Ave., Baltimore 28, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		DATE SIGNED <b>6-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17. Tel.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 25 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Lickner</b>			

# CERTIFICATE OF DEATH

STATE OF NEW YORK

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1910		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY	
MANAGER		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		JUN 26 1957		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
JUN 26 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6100

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
TOWN <u>Owings Mills</u> LENGTH OF STAY (in this place) <u>16 years</u>		TOWN <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Springdale Lane</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>W.</u> (Last) <u>Springer</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>26</u> (Year) <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 13, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aviation</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>	
13. FATHER'S NAME <u>Charles Wesley Springer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Grace Utz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1918-1919</u>		16. SOCIAL SECURITY No. <u>215-07-4894</u>	
17. INFORMANT <u>Wife Mrs. Ruth Springer</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Coronary thrombosis</u>		
Antecedent cause(s) (b) <u>Arteriosclerotic C.V.D.</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>0 422.1</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>9 Dec</u> , 19 <u>50</u> , to <u>26 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 May</u> , 19 <u>57</u> , and that death occurred at <u>5:20 A.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Charles H. Williams, M.D.</u> (Degree or title)		DATE SIGNED <u>26 June '57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 29, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>
LOCATION (City, town, or county) <u>Owings Mills, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>June 27, 1957</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>



RECEIVED

JUL 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6101

## CERTIFICATE OF DEATH

06097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Grove</b> Last <b>Stewart</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1859? May 31 st. 97 98</b>
9. AGE (In years last birthday) <b>97 98</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Fowler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>57</b> , to <b>June 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>57</b> , and that death occurred at <b>7:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 6-25-57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. R. W. [Signature]</b>		24a. REC'D BY REGISTRAR ADDRESS <b>1300 Eutaw Pl. 17</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		DATE <b>JUN 27 57</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1957	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		NAME OF PHYSICIAN [Illegible]	
NAME OF FUNERAL HOME [Illegible]		NAME OF BURIAL PLACE [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF WITNESS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF FUNERAL HOME [Illegible]		SIGNATURE OF WITNESS [Illegible]	

**RECEIVED**  
 JUN 28 1957  
 BUREAU V. 1

5946

## CERTIFICATE OF DEATH

06098

Reg. Dist. No.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Windsor</u>				c. LENGTH OF STAY IN b. <u>5 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NO Fourth Ave</u>				d. STREET ADDRESS <u>2626 St. Benedict St</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>Steupe</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22-1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>John S. Steupe</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Need</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-18-8747</u>			
17. INFORMANT <u>John S. Steupe</u>				Address <u>28-Fourth-Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, stomach with</u> <u>151X</u> DUE TO <u>generalized abdominal metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1956</u> to <u>June 17, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Arthur Rossberg MD</u>				ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore, Md.</u>			
DATE SIGNED <u>6/17/57</u>							
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG MD</u>				<u>Baltimore Co. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linden Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Elmo Support</u>				ADDRESS <u>1300 E. E. Ave</u>			
24a. REC'D BY REGISTRAR <u>Dr. G. M. Kupper</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kupper</u>			
DATE <u>JUN 20 1957</u>							

BUREAU V. 5

JUN 21 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6102

## CERTIFICATE OF DEATH

06099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>30 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2827 Topaz Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>L.</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1920</b>	
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cork &amp; Seal Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Carl Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Nell Maderia</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG</b> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19 12:15 PM</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>June 10, 19 57</b> to <b>June 10, 19 57</b> , that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>CHEN WEI LAN, M.D.</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>6/10/57</b> PHYSICIAN'S NAME (Type) <b>CHEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Ruck Funeral Home, 5305 Harford Rd., Baltimore 14, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 12 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Lawson L. Larkins</b>			

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3

BUREAU V. 8

JUN 12 1957

RECEIVED

6103

CERTIFICATE OF DEATH

06100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>55</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8420 Greenway Road</b>				d. STREET ADDRESS <b>8420 Greenway Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>M.</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 19, 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>		13. FATHER'S NAME <b>James Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Duff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Joseph Peverill</b>		Address <b>8420 Greenway Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mammary Carcinoma</b> DUE TO <b>left</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 17, 1957</b> to <b>June 27, 1957</b> , that I last saw the deceased alive on <b>June 28, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph F. Li Pira</b>				M.D. <b>8400 Loch Raven Blvd., Md.</b>			
PHYSICIAN'S NAME (Type) <b>Joseph F. Li Pira</b>				M.D. <b>8400 Loch Raven Blvd., Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Towson, Inc.</b>				ADDRESS <b>1050 York Rd.</b>			
24a. REC'D BY REGISTRAR <b>JUL 1 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6113

Reg. No. 11

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		WIDOWED		DIVORCED		SEPARATED		OTHER	
JAMES M. HILL		Male		45		July 2, 1957		Home		Heart Disease		Natural		None		None		None		None		None		None		None		None		None		None	
FATHER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
MOTHER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
BROTHER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
SISTER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
GRANDFATHER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
GRANDMOTHER		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
UNCLE		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
AUNT		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
NEPHEW		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
NIECE		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Cousin		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Other		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Signature		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Date		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Place		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Occupation		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Education		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Religion		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Marital Status		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Single		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Married		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Widowed		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Divorced		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Separated		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Other		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 3.

JUL 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

06101

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>6 Mths.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Parkville</u>		d. STREET ADDRESS <u>8703 Richmond Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND BASIL TEIXEIRA</u>		4. DATE OF DEATH Month Day Year <u>JUNE 27 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1925 JUNE 19, 1957</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PSYCHOLOGIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOARD OF EDUCATION</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Teixeira</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Tunney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>087-18-4136</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 1, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns, Son, Towson, Md.</u>		24a. REC'D BY REGISTRAR <u>July 1, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
DIVISION OF PUBLIC HEALTH  
Baltimore, Maryland

BUREAU V. 2.

1957 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06102

6105

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shadybrook Home</u>		d. STREET ADDRESS <u>1410 Balloon St</u>	
3. NAME OF DECEASED (Type or print) <u>Jane Contourney Thomas</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>abt 7/10/1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHAS E Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ann Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. M. Henry</u>		Address <u>1414 W. Latham St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 June</u> , 19 <u>57</u> , to <u>16 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 June</u> , 19 <u>57</u> , and that death occurred at <u>1:35 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John A Nesbitt Jr.</u> M.D. <u>1118 A Paul St.</u>		PHYSICIAN'S NAME (Type) <u>JOHN A NESBITT JR.</u> <u>Baltimore 2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE		DATE	

NEW YORK STATE DEPARTMENT OF HEALTH—BAYVIEW 13

JUN 18 1957

RECEIVED  
JUN 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6106

## CERTIFICATE OF DEATH

Reg. Dist. No. 06103 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>53 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1649 Argonne Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>O.</b> Last <b>THUMA</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 12, 1897</b>	
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Maryland U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John P. Thuma</b>				14. MOTHER'S MAIDEN NAME <b>Clara M. Kidd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>717-07-8382</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE RECTUM, WITH METASTASES</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 6</b> , 19 <b>57</b> , to <b>June 28</b> , 19 <b>57</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Armen Bogosian</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>6/28/57</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>				ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>							

BUREAU V. S.

JUL 2 1957

RECEIVED



1

6107

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Balto</i>	
CITY OR TOWN <i>Lochearn</i>		LENGTH OF STAY (in this place)		CITY OR TOWN <i>Lochearn</i>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3817 Arbutus Ave</i>				STREET ADDRESS <i>3817 Arbutus Ave</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<i>Elizabeth T. B. Linley</i>				<i>June 6, 1957</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>		8. DATE OF BIRTH <i>Sept 12, 1878</i>	
9. AGE last birthday <i>78</i> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Frederick Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry B. Tyson</i>				14. MOTHER'S MAIDEN NAME <i>Eugenia Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>18. MEDICAL CERTIFICATION</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
153x IMMEDIATE CAUSE (A) <i>Carcinoma of the bowel with metastasis to the lungs</i>						=	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-7</i> , 19 <i>57</i> , to <i>6-6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-4</i> , 19 <i>57</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>C. Herbert Mueller</i> M.D.				ADDRESS (Street, city, town, state) <i>5724 Winner Ave</i>			
DATE <i>6/11/57</i>				DATE SIGNED <i>6-7-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 9, 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dr. Wm. M. ...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers</i>		ADDRESS <i>50050 K. ... Balto. 15, Md</i>	

# CERTIFICATE OF DEATH

MADE IN THE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

AGE 100

DEATH RECORD NUMBER 1000000000

NAME AND

ADDRESS

DATE

TIME

PLACE

CAUSE

MANNER

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. 3

JUN 12 1957

RECEIVED

INSTRUCTIONS

100-1000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6108

Item 2 Film 6217 6-26-57 et

## CERTIFICATE OF DEATH

06105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE, MD</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		1 d. STREET ADDRESS <b>20 Aintree Road</b>	
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>TWELE</b> Last		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 22, 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CONRAD KAHL</b>		14. MOTHER'S MAIDEN NAME <b>FREDERICKA KAUFMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-22-7793</b>	
17. INFORMANT <b>Frank R. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiac</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>51</b> p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>4/7</b> , 19 <b>52</b> , to <b>6/17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/17</b> , 19 <b>57</b> , and that death occurred at <b>6:30</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter T. Hus</b>		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 24 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Redmond</b>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH JUNE 24 1957	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF BURIAL OFFICIAL [Faint text]		SIGNATURE OF MINISTER OF THE GOSPEL [Faint text]	
SIGNATURE OF CHURCH CLERK [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]	
SIGNATURE OF CEMETERY [Faint text]		SIGNATURE OF INTERVIEWER [Faint text]	
SIGNATURE OF RECORDS SECTION [Faint text]		SIGNATURE OF CHIEF OF BUREAU [Faint text]	

BUREAU V. 2

JUN 24 1957

RECEIVED

6109

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06106

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shawan</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>T.W.</b> Last <b>Van Horn</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1903</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Ward</b>				14. MOTHER'S MAIDEN NAME <b>Sally Thornton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr. Charles H. Buck - 215 E. Fayette St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive thoracic hemorrhage due to crushing injury of chest</b> 983X <del>EMPHYSEMA</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickerson &amp; Sons - Balt.</i>				24a. REC'D BY REGISTRAR DATE <b>6/6/57</b>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS DEATH CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED.  
It is to be filled out in the case of a death which has occurred in the State of Massachusetts, and in the case of a death which has occurred in the State of Massachusetts, and in the case of a death which has occurred in the State of Massachusetts.

NAME OF DECEASED: George A. Smith  
AGE: 45 YEARS  
SEX: Male  
RACE: White  
BIRTH: Jan. 1, 1882  
PLACE OF BIRTH: Van Hook, N.Y.  
DATE OF DEATH: June 7, 1957  
PLACE OF DEATH: Home  
CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural  
SIGNATURE OF MEDICAL EXAMINER: Dr. J. H. Smith  
DATE: June 7, 1957

BUREAU V. 8

JUN 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar at the time of burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6110

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0610731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>47 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2000 Mosby Ave.,</b>				d. STREET ADDRESS <b>2000 Mosby Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Webster</b> Last <b>Vaughn</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1909</b>		9. AGE (In years last birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George W. Vaughn</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Harris</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Anna M. Vaughn 2000 Mosby Ave.,</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M. D</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-8-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Howard Strong</b> ADDRESS <b>3107 W. NORTH AVE.</b>				24a. REC'D BY REGISTRAR <b>JUN 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. M. C. Martin</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 7 1957

RECEIVED

6111

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>				d. STREET ADDRESS <u>115 Symington Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Santa</u> Middle <u>Vazzana</u> Last <u>Vazzana</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 21, 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET. SELF-EMP.</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROSARIO VAZZANA</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES BARRANCO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Harry Vazzana 115 Symington Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>141X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Tongue</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/56</u> , 19 <u>57</u> , to <u>6/1/56</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/1/56</u> , 19 <u>57</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>I. S. ZINBERG</u> M.D. <u>2020 Eutam Rd</u>				PHYSICIAN'S NAME (Type) <u>I. S. ZINBERG M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 20 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 8

JUN 20 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6112

## CERTIFICATE OF DEATH

06109

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				c. LENGTH OF STAY IN 1b <b>15 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nicholas</b> Middle <b>Verdis</b> Last <b>Verdis</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1894</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Sebastian Verdis</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-5850</b>		17. INFORMANT <b>Sebastian Verdis, Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>148x Carcinoma of Pharynx</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cachexia</b> (c) <b>Cachexia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>30 Months</b> <b>18 Months</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 Months</b> <b>18 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-57</b> , to <b>6-4-57</b> , that I last saw the deceased alive on <b>6-2-57</b> , and that death occurred at <b>10A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James G. Saffell</b>				DATE SIGNED <b>6-4-57</b>			
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>				ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All-Saints</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6-5-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

# CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased John Joseph		Sex Male		Age 35		Date of Birth June 10, 1907	
Place of Birth Chicago, Ill.		Race White		Religion Catholic		Marital Status Single	
Cause of Death Sudden		Place of Death Chicago, Ill.		Date of Death June 10, 1942		Time of Death 7:30 P.M.	
Signature of Physician J. J. Smith		Signature of Registrar J. J. Smith		Signature of Deceased J. J. Smith		Signature of Next of Kin J. J. Smith	
Official Seal of the State Department of Health		Official Seal of the Bureau of Vital Statistics		Official Seal of the County Clerk		Official Seal of the City Clerk	

BUREAU V. S.

JUN 7 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 61113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

061110

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLIVER BEACH</u>				c. LENGTH OF STAY IN 1b <u>XODHIVER BEACH</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 14 BOX 228 BALTO 20</u>				d. STREET ADDRESS <u>ROUTE 14 BOX 228 BALTO 20</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE M WACHOB</u>				4. DATE OF DEATH Month Day Year <u>JUNE 14 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 17-1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN CO.</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>PA</u>	
13. FATHER'S NAME <u>JOHN WACHOB</u>				14. MOTHER'S MAIDEN NAME <u>ELIZ. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>GLADYS WACHOB</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>BALTO. CO. MD</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/17/57</u>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EDENEZER</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>			ADDRESS <u>Essex 21 Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 18 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Hurlburt</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

JUN 18 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6114

## CERTIFICATE OF DEATH

Reg. Dist. No.

06111

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>4622 Lacy Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Katherine</b> Last <b>Waidman</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1884</b>		9. AGE (In years last birthday) yrs. <b>72</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Christian Kieffler</b>				14. MOTHER'S MAIDEN NAME <b>Carolyn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 21</b> , 19 <b>57</b> to <b>June 7th</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 7th</b> , 19 <b>57</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Daniel Everett Edwards</b>							
PHYSICIAN'S NAME (Type) <b>DAVID EVERETT EDWARDS</b> <b>CATONSVILLE 28, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Switland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 517-11th St. S.E.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 12 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	



RECEIVED

BUREAU V. S.

JUN 12 1957

6115

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>High Hopes Farm Baldwin Md.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Leroy</u> Last <u>Walter</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1901</u>		9. AGE (In years last birthday) yrs. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supert. of Maintance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
13. FATHER'S NAME <u>Harry J. Walter</u>			14. MOTHER'S MAIDEN NAME <u>Emma Peppler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 10 4186</u>		17. INFORMANT <u>Mamie T. Walter High Hopes Farm Baldwin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
			20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>53</u> , to <u>6/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:30 A.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>			ADDRESS (Street, city or town, state) <u>Fork, Md.</u>		
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			DATE SIGNED <u>6/21/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saint Johns Episcopal</u>	
				22d. LOCATION (City, town, or county) (State) <u>Kingsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessah Funeral Home</u>			24a. REC'D BY REGISTRAR <u>6/24/57</u>		
ADDRESS <u>7401 Belvid Rd.</u>			24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Fennell</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

**RECEIVED**  
JUN 24 1957  
BUREAU V. 2

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 1, 1900</i>	
SEX <i>Male</i>		RACE <i>White</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md</i>	
DATE OF DEATH <i>June 20, 1957</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>38 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1501 Sudbrook Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Odenheimer White</u>				4. DATE OF DEATH Month Day Year <u>June 13 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Jan 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing &amp; Sheet Metal</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Charles A. White</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fitzell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-034726</u>		17. INFORMANT <u>Miss Elsie White</u> Address <u>501 Sudbrook Pikesville 8 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>7 or years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>13 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 June</u> , 19 <u>57</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u>				ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd.</u>		DATE SIGNED <u>13 June 57</u>	
PHYSICIAN'S NAME (Type) <u>Paul H Royse MD.</u>				<u>Pikesville 8 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 15 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8 Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Nantz</u>				ADDRESS <u>Pikesville</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Nantz</u>	

# CERTIFICATE OF DEATH

6-10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. PLACE OF DEATH [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	
<p>15. SIGNATURE OF DECEASED [Faint text]</p>		<p>16. SIGNATURE OF WITNESS [Faint text]</p>	
<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>	
<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF WITNESS [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF WITNESS [Faint text]</p>	
<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF WITNESS [Faint text]</p>	
<p>25. SIGNATURE OF DECEASED [Faint text]</p>		<p>26. SIGNATURE OF WITNESS [Faint text]</p>	
<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF WITNESS [Faint text]</p>	
<p>29. SIGNATURE OF DECEASED [Faint text]</p>		<p>30. SIGNATURE OF WITNESS [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF WITNESS [Faint text]</p>	
<p>33. SIGNATURE OF DECEASED [Faint text]</p>		<p>34. SIGNATURE OF WITNESS [Faint text]</p>	
<p>35. SIGNATURE OF DECEASED [Faint text]</p>		<p>36. SIGNATURE OF WITNESS [Faint text]</p>	
<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF WITNESS [Faint text]</p>	
<p>39. SIGNATURE OF DECEASED [Faint text]</p>		<p>40. SIGNATURE OF WITNESS [Faint text]</p>	
<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF WITNESS [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF WITNESS [Faint text]</p>	
<p>45. SIGNATURE OF DECEASED [Faint text]</p>		<p>46. SIGNATURE OF WITNESS [Faint text]</p>	
<p>47. SIGNATURE OF DECEASED [Faint text]</p>		<p>48. SIGNATURE OF WITNESS [Faint text]</p>	
<p>49. SIGNATURE OF DECEASED [Faint text]</p>		<p>50. SIGNATURE OF WITNESS [Faint text]</p>	
<p>51. SIGNATURE OF DECEASED [Faint text]</p>		<p>52. SIGNATURE OF WITNESS [Faint text]</p>	
<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF WITNESS [Faint text]</p>	
<p>55. SIGNATURE OF DECEASED [Faint text]</p>		<p>56. SIGNATURE OF WITNESS [Faint text]</p>	
<p>57. SIGNATURE OF DECEASED [Faint text]</p>		<p>58. SIGNATURE OF WITNESS [Faint text]</p>	
<p>59. SIGNATURE OF DECEASED [Faint text]</p>		<p>60. SIGNATURE OF WITNESS [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF WITNESS [Faint text]</p>	
<p>63. SIGNATURE OF DECEASED [Faint text]</p>		<p>64. SIGNATURE OF WITNESS [Faint text]</p>	
<p>65. SIGNATURE OF DECEASED [Faint text]</p>		<p>66. SIGNATURE OF WITNESS [Faint text]</p>	
<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF WITNESS [Faint text]</p>	
<p>69. SIGNATURE OF DECEASED [Faint text]</p>		<p>70. SIGNATURE OF WITNESS [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF WITNESS [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF WITNESS [Faint text]</p>	
<p>75. SIGNATURE OF DECEASED [Faint text]</p>		<p>76. SIGNATURE OF WITNESS [Faint text]</p>	
<p>77. SIGNATURE OF DECEASED [Faint text]</p>		<p>78. SIGNATURE OF WITNESS [Faint text]</p>	
<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF WITNESS [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF WITNESS [Faint text]</p>	
<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF WITNESS [Faint text]</p>	
<p>85. SIGNATURE OF DECEASED [Faint text]</p>		<p>86. SIGNATURE OF WITNESS [Faint text]</p>	
<p>87. SIGNATURE OF DECEASED [Faint text]</p>		<p>88. SIGNATURE OF WITNESS [Faint text]</p>	
<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF WITNESS [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF WITNESS [Faint text]</p>	
<p>93. SIGNATURE OF DECEASED [Faint text]</p>		<p>94. SIGNATURE OF WITNESS [Faint text]</p>	
<p>95. SIGNATURE OF DECEASED [Faint text]</p>		<p>96. SIGNATURE OF WITNESS [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF WITNESS [Faint text]</p>	
<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

JUN 17 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06114

6117

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>8 WKS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>381 ENDWOOD LANE</u>			1d. STREET ADDRESS <u>381 ENDWOOD LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEROLYN R. WHYE</u>			4. DATE OF DEATH Month Day Year <u>6 23 1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 27, 1957</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>23</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>LEON WILLIAMS</u>		
14. MOTHER'S MAIDEN NAME <u>GLADYS WHYE</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT Address <u>GLADYS WHYE - 381 ENDWOOD LANE, TOWSON MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Pneumonia</u> DUE TO (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>12 Hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/24/57</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEPHENSON</u>	
22d. LOCATION (City, town, or county) <u>SPARKS, MD.</u>		(State) <u>MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 26, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mark L. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Blanton Jr. - 1701 M. Cullors St. - Baltimore, Md.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

06115

6118

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Max</b> Middle <b>Wichner</b> Last <b>Wichner</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>baker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>							
13. FATHER'S NAME <b>Israel Wichner</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Berstein</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 5, 19 57</b> , to <b>June 14, 19 57</b> , that I last saw the deceased alive on <b>June 14, 19 57</b> , and that death occurred at <b>1:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 6-14-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Israel</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>				ADDRESS <b>2100 Canton Place</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 18 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Smith</b>							

BUREAU V. S.

JUN 18 1957

RECEIVED  
JUN 18 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06116

6119

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova Balto</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>7. (Villa Nova)</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>3613 Buckingham Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Howard</u> Middle <u>Wilkie</u> Last				4. DATE OF DEATH <u>June 13, 1957</u> Month <u>June</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 28, 1879</u> 77 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Bus</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Wilkie</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-32-5337</u>		17. INFORMANT <u>Mrs Catherine Lossner</u> Address <u>3613 Buckingham</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Head of Pancreas</u> 157x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1 yr.</u> DUE TO (c) <u>1 yr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> Address <u>5005 Pk Heights Ave Balto 15 Md.</u>				24a. REC'D BY REGISTRAR <u>Dr Wm Martin</u> DATE <u>6/10/57</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial, cremation, or removal.



# STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 6120  
 CERTIFICATE OF DEATH

06117

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balt. City</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. LENGTH OF STAY IN 1b <i>12 yrs 28 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas David</i> First Middle Last <i>Wilkie</i>				4. DATE OF DEATH Month <i>JUNE</i> Day <i>8</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jul 24 1892</i>		9. AGE (In years last birthday) <i>64</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minister</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas David Wilkie</i>				14. MOTHER'S MAIDEN NAME <i>Nellie Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-01-6365</i>		17. INFORMANT Address <i>Records: Spring Grove State Hospital</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 cerebro-vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>epilepsy</i> DUE TO (c) <i>arteriosclerotic cardio-vascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>358.3</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 11</i> , 19 <i>47</i> , to <i>JUNE 8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>JUNE 04</i> , 19 <i>57</i> , and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles Ward</i>				ADDRESS (Street, city or town, state) <i>Spring Grove State Hospital</i>			
PHYSICIAN'S NAME (Type) <i>DR. CHARLES WARD</i>				DATE SIGNED <i>JUN 10 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>6-14-57</i>		<i>Wt. OLIVE</i>		<i>BALTO MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wm. Cook Inc. 1217 St. Paul St</i>				24a. REC'D BY REGISTRAR <i>DATE 6/10/57</i>		24b. REGISTRAR'S SIGNATURE <i>R. H. Hedrich</i>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

6121

## CERTIFICATE OF DEATH

061183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BAIT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowling's Mills MD.</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE MD. 3 vol-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. STREET ADDRESS <u>1526 N Smalwood St.</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel Ellen Williams</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/54</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.	IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Paul S. Williams</u>	
14. MOTHER'S MAIDEN NAME <u>EVA E. Sloane Williams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.4</u> DUE TO <u>Status Epilepticus - {Epilepsy began at 1 yr of life}</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Congenital heart disease</u> DUE TO <u>Birth (31 years)</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>353.2</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-7</u> , 19 <u>57</u> , to <u>6-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>57</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		ADDRESS (Street, city or town, state) <u>Rosewood State Training School</u> DATE SIGNED <u>18 June 57</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		<u>Rosewood State Training School</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JUN 21, 57</u>	<u>BALTO. NAT'L.</u>	<u>BALTIMORE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>1631 Druid Hill Ave.</u>		<u>JUN 19 1957</u>	<u>Mary Eline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JUN 19 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6122

CERTIFICATE OF DEATH

06119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN IB <b>22 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Baltimore (22)</b>		d. STREET ADDRESS <b>6917 German Hill Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DALTON</b> Last <b>WIMMER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 30, 1927</b>
9. AGE (In years last birthday) yrs. <b>29</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Specialist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Products</b>	
11. BIRTHPLACE (State or foreign country) <b>Dayton, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oscar Wimmer</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Carr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>		16. SOCIAL SECURITY NO. <b>218-22-2992</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>5928</b> DUE TO CHRONIC GLOMERULAR NEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 28, 1957</b> , to <b>June 19, 1957</b> and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above. <b>XXXXXX</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>6/19/57</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JUNE 21-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>I. G. Connelly &amp; Sons, 418 Eastern Ave., Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 21 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. L. Hickey</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

BUREAU V. S.

JUN 21 1957

RECEIVED

6123

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
c. LENGTH OF STAY in lb <u>3 yrs.</u>		d. STREET ADDRESS <u>1 566 Old Edmondson Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAK Hill Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA M. WINTERS</u> First Middle Last		4. DATE OF DEATH <u>JUNE 23 1957</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7-1858</u> 9. AGE (In years last birthday) <u>99</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>PENNINGTON</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>MR. HARRY R. WINTERS</u> Address <u>143 COLLINS AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C-V-D</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Agitated Psychosis 1 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/16/47</u> , 19___, to <u>6/23/57</u> , 19___, that I last saw the deceased alive on <u>6/21/57</u> , 19___, and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Arthur Rosenberg MD</u>		ADDRESS (Street, city or town, state) <u>3436 Washington Blvd Balto-30 Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSENBERG MD</u>		DATE SIGNED <u>6/24/57</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OLD BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 26 '57</u>
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6124

CERTIFICATE OF DEATH

06121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN lb <b>32 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>3137 Keswick Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Eleanor Regina Wolf</b>		4. DATE OF DEATH <b>June 1 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-1880</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Matron</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wolf</b>		14. MOTHER'S MAIDEN NAME <b>Frederica Hess</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>212-09-4438 A</b>	
17. INFORMANT <b>Admission Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>5 YRS.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>443X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 31, 1957</b> , to <b>June 1, 1957</b> , that I last saw the deceased alive on <b>May 31, 1957</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		DATE SIGNED <b>6/1/57</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Fredrick Rd Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan</b>		24a. REC'D BY REGISTRAR <b>June 6 1957</b>	
ADDRESS <b>3815 Polans Ave</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Edwards</b>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

0612240

6125

1. PLACE OF DEATH a. COUNTY <b>Bal to</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baldwin</b>				c. LENGTH OF STAY IN 1b <b>17 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>—</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gora Kidder Wood</b>				4. DATE OF DEATH Month Day Year <b>June 11 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 22, 1862</b>	9. AGE (In years last birthday) <b>95 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>3 21</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Geneseo N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Willard Kidder</b>				14. MOTHER'S MAIDEN NAME <b>Louise Kendall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Therese Marshall Turner Baldwin Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen. Arteriosclerosis</b> DUE TO (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>?</b> <b>Act. 95</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0 Chr. Polyposis &amp; Colitis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>41</b> , to <b>6-11-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-11-</b> , 19 <b>57</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3105 N. Charles St.</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert H. Silver</b> M.D. PHYSICIAN'S NAME (Type) <b>R. H. Silver</b> <b>Baltimore, 18, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Highland Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Haute Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin G. Smith</b>				24a. REC'D BY REGISTRAR <b>Dr. Walter Hammett</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Goldwin  
R. To

Goldwin  
Maryland

Female White  
House Wife  
Willard Fickler

Goldwin  
Fickler Wood  
June 11

Genesee Hill  
Folkie Kendall

510

BUREAU V. 3

JUN 14 1957

RECEIVED

H. Spina Lora

Spina

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

5943 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				06123			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Reg. Dist. No. 41			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>DUNDAIK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 MAIN STREET</u>				d. STREET ADDRESS <u>1517 MAIN STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM JAMES WORRELL</u>				4. DATE OF DEATH Month Day Year <u>JUNE 16 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9 1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REVERA Copper</u>		11. BIRTHPLACE (State or foreign country) <u>CONWAY, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY WORRELL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-9988</u>		17. INFORMANT <u>LEOLA E. WORRELL</u> Address <u>- 517 MAIN ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		DATE SIGNED <u>6/17/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Pk.</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES R. LAW - 802 MADISON AVENUE</u>				24. REG'D BY REGISTRAR <u>JUN 18 1957</u>			
ADDRESS				25. REGISTRAR'S SIGNATURE <u>Thos. Kelly</u>			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME (Last, First, Middle)		AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
TIME OF DEATH		DATE OF DEATH		SIGNATURE OF EXAMINER	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS	
TOXICOLOGY		ANTHROPOLOGY		FORENSIC FINDINGS	
OTHER FINDINGS		REMARKS		SIGNATURE OF WITNESS	
DATE OF REPORT		REPORT MADE AT		REPORT MADE BY	

BUREAU V. 3

JUN 18 1957

RECEIVED



6126

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8313 Loch Raven Blvd</i>		e. STREET ADDRESS <i>1 8313 Loch Raven Blvd</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Amelia Rose Young</i>		4. DATE OF DEATH Month <i>June</i> Day <i>27th</i> Year <i>19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 13, 1879</i>
9. AGE (In years lost birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Belfort, New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Violet</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Weaver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Norine Estes</i>		Address <i>8313 Loch Raven Blvd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>2:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William H. Fusting</i> M.D.		ADDRESS (Street, city or town, state) <i>4230 Loch Raven Blvd</i> DATE SIGNED <i>6/27/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. William H. Fusting</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/29/57</i>	22c. NAME OF CEMETERY OR CREMATOR <i>Moreland Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto; Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

JUN 28 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH _____		COUNTY _____	
CITY _____		STATE _____	
DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	

BUREAU V. S.

JUN 28 1957

RECEIVED

6127

## CERTIFICATE OF DEATH

Reg. Dist. No.

06125  
44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>30 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1142 N. GILMOR STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>P</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE THOMAS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-11</b>		16. SOCIAL SECURITY NO. <b>218-05-1129</b>	
17. INFORMANT <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus 260x</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that <b>VA</b> attended the deceased from <b>June 5, 1957, 11:00 AM</b> to <b>June 6, 1957, 5:00 PM</b> and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 6/7/57</b> ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND 6/7/57</b> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D. Chief Medical Service</b>			
22a. BURIAL (Specify) <b>Hyco Baptist Cemetery</b>		22b. DATE THEREOF <b>June 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Camden, S. Carolina</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802 Madison Ave. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6/8/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>			

SHIPPED TO: HALE FUNERAL HOME, CAMDEN, SOUTH CAROLINA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 12 1957

BUREAU V. S.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JUNE 10, 1957		HARRIS HOSPITAL	
AGE		SEX		RACE	
68		M		W	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH	
JAN 1, 1889		BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		EDUCATION		MARRIAGE	
RETIRED		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE	
HEART DISEASE		CORONARY THROMBOSIS		HYPERTENSION	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
NATURAL		123456789		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		PLACE		CITY	
JUNE 12, 1957		BALTIMORE, MD		BALTIMORE, MD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5944 CERTIFICATE OF DEATH

06126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. LENGTH OF STAY IN 1b <u>14 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 DELMAR AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE VOTAVA ZEIGA FUSE</u>				4. DATE OF DEATH Month Day Year <u>JUNE 11 1957</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20, 1911</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXAMINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING, MFG</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>CHARLES VOTAVA</u>				14. MOTHER'S MAIDEN NAME <u>ANN HEIM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>(?)</u>			
17. INFORMANT <u>HAROLD ZEIGA FUSE</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>171X</u> DUE TO <u>① CA Lung, ② CA Cervix Uteri</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> to <u>May 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>57</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thome Groner</u>				ADDRESS (Street, city or town, state) <u>MD.</u>			
PHYSICIAN'S NAME (Type) <u>Thome Groner</u>				DATE SIGNED <u>6/11/57</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/14/57</u>		<u>GARDENS OF FAITH</u>		<u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Banks Bradley, Dundalk 22 Md.</u>				24a. RECORDING REGISTRAR <u>JUN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thm Kelly</u>	



**BUREAU V. 8**

JUN 14 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,13,14 -Birth cert. B.C.H.D. 7-18-57 ams

6128

## CERTIFICATE OF DEATH

Reg. Dist. No.

061273

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, M.D.</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Rogers Rosewood Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>211 S. Calhoun</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Zijac</u> Last <u>Zijac</u>		4. DATE OF DEATH Month <u>6/7</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>11r</u> yrs. IF UNDER 1 YEAR Months <u>6</u> Days <u></u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>University Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased (Dmitro)</u>		14. MOTHER'S MAIDEN NAME <u>Deceased (Elva)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>Rosewood Training School</u> <u>Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis</u> <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Hydrocephalus &amp; convulsions</u> (c) <u>Pyelitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>Congenital to Rosewood since adm</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture baby - always a feeding problem &amp; poor nutrition</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/1/57</u> , 19 <u>57</u> , to <u>6/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/7/57</u> , 19 <u>57</u> , and that death occurred at <u>5:55P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Viola B. Johns</u>		ADDRESS (Street, city or town, state) <u>M.D. Rosewood, Owings Mills, Md</u> DATE SIGNED <u>6/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Viola B. Johns, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL</u>	22d. LOCATION (City, town, or county) (State) <u>FAUOAH W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Coch</u>		ADDRESS <u>2716 E. Monument St.</u>	24a. REC'D BY REGISTRAR DATE <u>6/10/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06128

6129

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Co.</b>		d. STREET ADDRESS <b>805 N. Washington St.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ZINGOR</b> Last <b>ZINGOR</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Doubek</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Benedict</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Lillian Z. Gray, daughter, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Hypertensive Arteriosclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/12</b> , 19 <b>57</b> , to <b>6/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/13</b> , 19 <b>57</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Kammerer</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>6011 York Rd. Balt., Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Kammerer</b>		<b>6011 York Rd. Balt. 12, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR <b>JUN 18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Grupp</b>			

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JUN 18 1957

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